

**How does community mobilisation through MaiMwana women's groups work?:  
Addressing the social determinants of mother and child health in rural Malawi.**

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## **Declaration**

I, Michele Rosato, declare that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Michele Rosato

May 2012

## **Acknowledgements**

The MaiMwana Project family...mutu umodzi susenza denga.

## **Abstract**

*Background:* Over 340,000 maternal and 8 million child deaths occur globally every year. These deaths are underpinned by physiological, behavioural and social determinants. Efforts to achieve Millennium Development Goals 4 and 5 for mother and child health have predominantly sought to address the physiological and behavioural risk factors. A few community mobilisation interventions, particularly those seeking to empower communities, have also sought to reduce mortality by addressing the social determinants of health but little is known about how they work. This thesis attempts to address this by illuminating the socio-environmental mechanism through which the MaiMwana women's group intervention in Malawi reduced maternal and child mortality.

*Methods:* A grounded theory methodology, utilising observation and focus group discussion methods was used to explore how the actions of the MaiMwana women's group intervention helped to organise and mobilise community members to take control of the social determinants of mother and child health.

*Results:* The actions of the MaiMwana women's group intervention built the capacities (knowledge, skills, opportunities and attitudes) of community members to become increasingly organised and mobilised (coming together, identifying common problems, receiving structure and direction, becoming organised, mobilising resources, developing partnerships, becoming critically conscious of the root causes of their problems, receiving power to take control of the women's group programme and actually taking this control) which in turn generated interpersonal elements (resources and relationships) that they could draw on to address the social determinants of mother and child health.

*Discussion:* The MaiMwana women's group intervention reduced maternal and child mortality by empowering women's group members to harness the interpersonal elements that arose as they became organised and mobilised and bring them to bear on the structural and intermediary social determinants of health through individual, organisational and community action thus reducing their exposure and vulnerability to health-compromising conditions.



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## **Additional material**

A DVD containing the following visual materials is attached in the back cover of this thesis.

1. Rosato M and Otanez M. Umodzi [DVD]. London: UCL, Centre for International Health and Development; 2010. 1 DVD: 14 min., sound, colour, HD. Available from: <https://vimeo.com/12427420>
2. Rosato M. Chimvano cha mabvu [slide]. London: UCL, Centre for International Health and Development; 2010. 35 slides: sound, colour. Available from: <http://vimeo.com/18396454>
3. Rosato M. M+E= [DVD]. London: UCL, Centre for International Health and Development; 2011. 1 DVD: 12 min., sound, colour, HD. Available from: <https://vimeo.com/25027515>

## List of abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ASTOR	Aims, setting, target group, objectives/methods and resources
CADECOM	Catholic Development Commission in Malawi
CCCSARS	Community Coalition Concerned about SARS, Canada
CMI	Community Mobilisation Intervention within the Avahan AIDS Initiative, India
CSDH	Commission on the Social Determinants of Health
CWO	Catholic Women's Organisation, Nigeria
FGD	Focus group discussion
FTO	Facilitation and training officer
GNP	Gross national product
HDI	Human development index
HIV	Human immunodeficiency virus
HSA	Health surveillance assistant
IGA	Income generating activity
IMR	Infant mortality rate
ITN	Insecticide treated nets
MCH	Mother and child health
MDG	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MICS	Multiple indicator cluster survey
MIRA	Mother and Infant Research Activities, Nepal
MK	Malawi kwacha
MMR	Maternal mortality ratio
MP	Member of parliament
NMR	Neonatal mortality rate
NSO	National Statistics Office (Malawi)
OBS	Observation
PCP	Perinatal Care Project, Bangladesh
PMNCH	The Partnership for Maternal, Neonatal and Child Health
PMR	Perinatal mortality rate
PNC	Postnatal care
PRA	Participatory rural appraisal
SDH	Social Determinants of Health
SFTO	Senior facilitation and training officer
SNEHA	Society for Nutrition, Education and Action, India
STI	Sexually transmitted infection

TA	Traditional authority
TBA	Traditional birth attendant
UK	United Kingdom
UNDP	United Nations Development Programme
USA	United States of America
VCT	Voluntary counseling and testing
VF	Volunteer facilitator
VH	Village headman
WHO	World Health Organisation
ZF	Zonal facilitator

## **Chapter 1: Mother and child health and mortality**

### **1.1 Introduction**

There is increasing evidence to suggest that community mobilisation interventions are effective at improving mother and child health (MCH) and reducing mortality. However, little is known about how they work. Specifically, previous work has failed to describe the socio-environmental mechanisms through which such interventions address the social determinants of health (SDH) and are therefore improving health and reducing mortality. In this context, this thesis focuses on the MaiMwana women's group intervention in Mchinji district, Malawi. This intervention significantly improved care and care-seeking behaviours and reduced the maternal mortality ratio (MMR) as well as leading to smaller, non-significant, reductions in perinatal (PMR), neonatal (NMR) and infant mortality rates (IMR), particularly in years 2 and 3 of the study (Table 1a - page 20; Lewycka et al, Submitted). This thesis aims to surface the complete socio-environmental mechanism through which this intervention is improving MCH and reducing mortality; something that has not been done for any other community mobilisation intervention.

Table 1a: Impact of MaiMwana women's groups on key primary and secondary outcomes  
(Lewycka et al, Submitted)

Outcome	Adjusted for stratification, clustering, cluster-level baseline values, socioeconomic quintile and parity (Years 1 to 3)	Adjusted for stratification, clustering, cluster-level baseline values, socioeconomic quintile and parity (Years 2 and 3)
	<i>adjusted odds ratio (95% CI)</i>	<i>adjusted odds ratio (95% CI)</i>
PMR <i>per 1000 live births</i>	0.99 (0.82-1.21)	0.91 (0.70-1.18)
NMR <i>per 1000 live births</i>	0.97 (0.74-1.28)	0.85 (0.59-1.22)
IMR <i>per 1000 live births</i>	1.05 (0.86-1.29)	0.96 (0.77-1.20)
MMR <i>per 1000 live births</i>	0.77 (0.49-1.21)	0.48 (0.26-0.91)
Antenatal care at a health facility	1.50 (1.03-2.19)	1.37 (0.93-2.03)
Skilled birth attendance	1.22 (0.91-1.65)	1.18 (0.84-1.65)



## **1.2 Maternal mortality and morbidity**

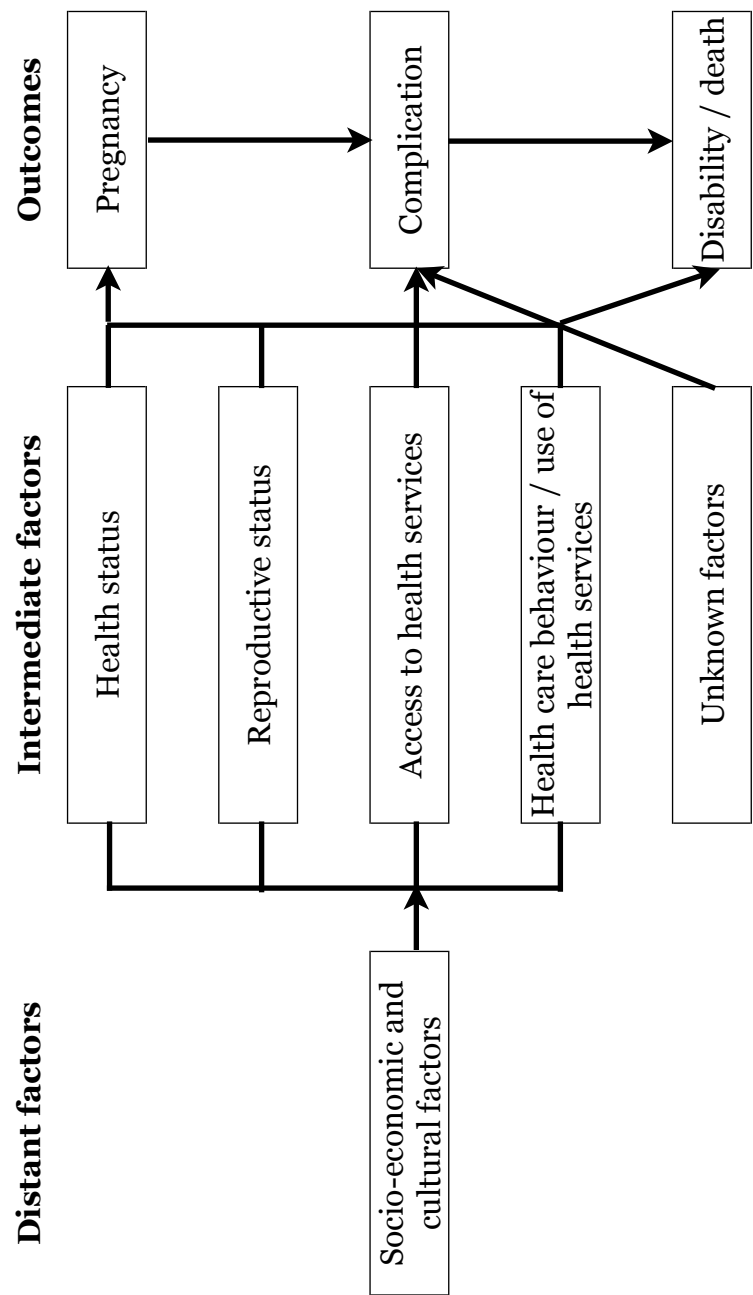
Hogan et al (2010) found that approximately 342,900 maternal deaths occurred globally in 2008. This represents an MMR of approximately 260 deaths per 100,000 live births and a lifetime risk of maternal death of approximately 1 in 140 (World Health Organisation (WHO) et al, 2010). The report showed that 99% of these maternal deaths occurred in developing countries and over 50% occurred in sub-Saharan Africa. Indeed, the MMR for sub-Saharan Africa was reported to be approximately 640 per 100,000 live births compared to 280 per 100,000 in Asia and 14 per 100,000 in developed nations (WHO et al, 2010).

For methodological reasons it is difficult to determine temporal trends in maternal mortality. However, recent studies have shown that MMR has decreased by 41% globally since 1980 (WHO et al, 2010; Hogan et al, 2010). This progress has not been reflected in sub-Saharan Africa over the past few decades (Ronsmans et al, 2006). Indeed, comparisons of WHO datasets have shown that the smallest reduction in maternal mortality between 1990 and 2005 took place in sub-Saharan Africa (Shah and Say, 2007).

For every woman who dies, another 30 women suffer long-lasting injury or illness that can result in lifelong pain, disability and socio-economic exclusion (O'Loughlin, 1997). Little research had been undertaken on disabilities related to pregnancy and childbirth in developing countries. However, it is likely that most serious disabilities result from nonfatal conditions such as chronic urinary tract infection, uterine prolapse, and vaginal fistulae (McCarthy and Maine, 1992).

McCarthy and Maine (1992) developed a comprehensive framework to analyse the determinants of maternal mortality (Figure 1b - page 22). The framework proposes that a woman must be pregnant and experience some complication of pregnancy or childbirth for her death to be defined as a maternal death. This sequence of outcomes is directly influenced by five sets of intermediate factors. These include her: health status, reproductive status, access to health services, health care behaviour, and other unknown factors. These are, in turn, influenced by a set of distant factors, which include socio-economic and cultural factors (these will be discussed in Section 1.4 below).

Figure 1b: A framework for analyzing the determinants of maternal mortality and morbidity (McCarthy and Maine, 1992)



### **1.2.1 Complications**

Maternal deaths can be classified as either direct or indirect. Direct obstetric deaths are due to complications of pregnancy, delivery, or the postpartum period. The category ‘complications’ in the McCarthy and Maine (1992) framework refers to these direct contributing factors and will be discussed here. Globally these complications account for 80% of maternal deaths (WHO, 2007). Indirect obstetric deaths are due to existing medical conditions that are made worse by the pregnancy or delivery. These contributing factors are a component of a ‘woman’s health status’, one of the intermediate determinants, and will be discussed below.

Globally, the most common direct causes of maternal mortality include haemorrhage, sepsis, pre-eclampsia, obstructed labour and unsafe abortion (Table 1c - page 24). In 2000, the direct cause of maternal mortality with the highest incidence was unsafe abortion which occurred in 14% of live births, amounting to 68,000 maternal deaths related to abortion each year at a case fatality rate of 0.3% (Abou-Zahr, 2003). In 2000, 10.5% of live births resulted in severe post-partum haemorrhage (Abou-Zahr, 2003). Approximately 140,000 women died as a result; a case fatality rate of approximately 1% (Abou-Zahr, 2003). 4.6% of live births in 2000 experienced obstructed labour which had a case fatality rate of (0.7%) and thus resulted in over 40,000 women dying from this complication. Sepsis was slightly less common in 2000, occurring in 4.4% of live births, but had a higher case fatality rate (1.3%) and accounted for approximately 77,000 maternal deaths (Abou-Zahr, 2003), although it should be noted that most surveys underestimate the likely number of deaths where sepsis is an important or contributory cause. Finally, pre-eclampsia occurred in an estimated 3.2% of live births in 2000, and had the highest case fatality rate of 1.7% which translates to approximately 72,000 maternal deaths (Abou-Zahr, 2003).

Table 1c: Estimated incidence of major obstetric complications and main maternal sequelae (2000) (Abou-Zahr, 2003)

Complication	Incidence (% of live births)	Cases	Case fatality rate (%)	Maternal deaths	Main sequelae
Abortion	14.8	19,340,000	0.3	69,000	Infertility
Severe post-partum haemorrhage	10.5	13,795,000	1.0	132,000	Severe anaemia
Obstructed labour	4.6	6,038,000	0.7	42,000	Urinary incontinence, fistula
Sepsis	4.4	5,768,000	1.3	79,000	Infertility
Pre-eclampsia/eclampsia	3.2	4,152,000	1.7	63,000	Eclampsia

### **1.2.2 Intermediate factors**

#### **Health status**

A woman's health status prior to and during pregnancy influences her chance of developing and surviving complications (McCarthy and Maine, 1992). Globally, the key indirect causes are Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), anaemia and malaria (Ronsmans et al, 2006; Brabin et al, 2001; WHO, 2007). Evidence suggests that HIV is a leading cause of pregnancy related death in some hospital studies (Ahmed et al, 1999). Furthermore, there is evidence of its importance as a cause of maternal death in populations with high HIV prevalence (Sewankambo et al, 2000; Le Coeur et al, 2005; Fawcus et al, 2005; Ronsmans et al, 2006). Although the exact global contribution of HIV to maternal deaths is unknown it is hypothesised to increase the risk of obstetric complications in a number of ways. HIV related illnesses such as anaemia and tuberculosis may be aggravated by pregnancy, pregnancy may increase HIV incidence, HIV progression may be worsened by pregnancy, quality of care may deteriorate in the context of high HIV prevalence due to acute shortages of health professionals, and women with HIV may receive poorer services as a result of stigmatisation (Graham and Newell, 1999; Ronsmans et al, 2006). Anaemia is a leading indirect cause of maternal death globally and was estimated to contribute to 6% of maternal deaths in Africa in 2000 (Brabin et al, 2001). It is associated with placental malaria which has also been found to contribute to premature delivery, intra-uterine growth retardation, low birth weight and infant mortality (WHO, 2007; Filler et al, 2006; Schulman and Phillips, 2003). In its own right mortality related to malaria can be very high and research suggests that pregnant women are more susceptible to it compared to the general population (WHO, 2007). Anaemia is also associated with malaria as it can increase the frequency and parasite density of malaria infections during pregnancy (Steketee et al, 1996). Other key aspects of women's health status include: nutritional status, infections and parasitic diseases (for example, hepatitis and tuberculosis), chronic conditions (for example, diabetes and hypertension), and previous history of pregnancy complications (for example, caesarean section and abortion) (McCarthy and Maine, 1992).

#### **Reproductive status**

The link between women's reproductive characteristics and maternal mortality have been well documented. They include: age, parity, and birth spacing (McCarthy and Maine, 1992; Maine, 1987). In terms of age and parity, risks are understood to be higher for very young women, women over 35 years of age and those with more than four children (McCarthy and Maine, 1992). They are also associated with disabilities such as fistula and uterine prolapse (Tahzib, 1989; Omran and Standley, 1976). Birth spacing has a similar relationship with maternal and child mortality and maternal disability (Maine, 1987). Marital status is an additional characteristic that has also been hypothesised to have a relationship with maternal survival (McCarthy and Maine, 1992).

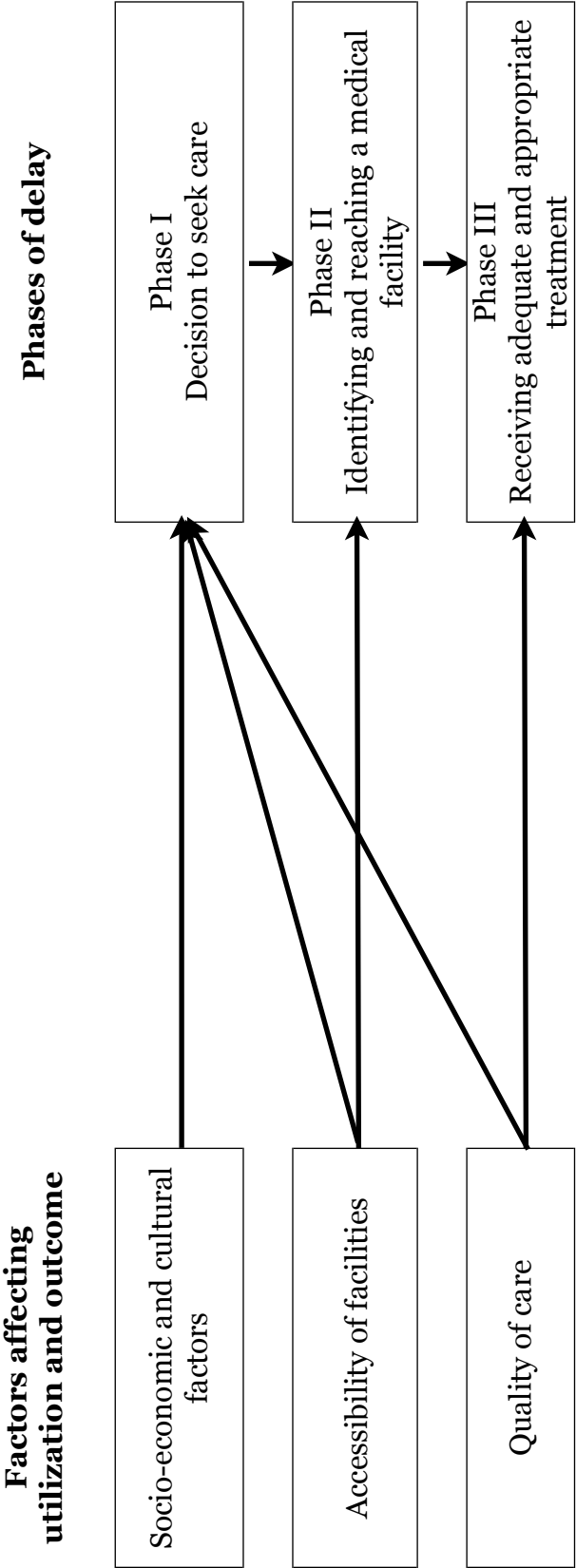
## **Access to health services**

Access to maternal health services is essential to addressing maternal mortality. As Ronsmans et al (2006) stated, “Progress [on maternal mortality] will ultimately be dependent on strong health systems ensuring high coverage of midwifery services supported by timely and competent hospital care, especially in the poorest countries in sub-Saharan Africa and south Asia”. To be most effective these services need to be of high quality and offer treatments for women to have safe and successful delivery and options for women who want to avoid pregnancy and childbirth. However, in reality, maternal health services in developing countries are generally limited in quality and staffing levels. These characteristics are exacerbated in areas of high HIV prevalence where facilities may be overcrowded, taking funding away from other services, and where health workers may themselves be infected (McCoy et al, 2005). Where services do exist, access may be limited by other factors including distance, the cost of user fees, previous experiences related to poor performance by health workers and perceptions of poor treatment of women by health facility staff (McCoy et al, 2005). These factors have all been shown to be associated with maternal mortality (Fortney, 1985; Walker, 1985; Ekwempu et al, 1990; Omu, 1981)

## **Health care behaviours**

Health care behaviours can be divided into care behaviours and care-seeking behaviours. Care behaviours are all the relevant antenatal, delivery and postnatal care (PNC) practices, including essential health care behaviours such as bed net usage and hygiene and sanitation practices, and also traditional beliefs and practices, some of which may be harmful. Care-seeking behaviours refer to the actual use of antenatal, delivery and postnatal services. As discussed above, care seeking behaviours are in part a function of the availability, accessibility and quality of services but they are also a function of the actual use of these services by individuals. Thaddeus and Maine (1994) developed a model that included these two functions. The model described the three delays that contribute to maternal deaths (Figure 1d - page 27). The first delay refers to recognition of the problem and the need to seek medical help. The second delay refers to reaching an appropriate facility, and can be due to weak referral systems, cultural, social or financial factors. The third delay refers to receiving appropriate care on arriving at the facility and can be considerable where facilities are understaffed and patient numbers are unmanageable. Inadequate equipment, training and supervision may also contribute to poor quality care. The model proposes that where availability, accessibility, quality and use of health services is limited this can lead to delays and thus maternal complications, disability and death.

Figure 1d: The three delays model (Thaddeus and Maine, 1994)



Unfortunately, women who have access to high quality health services, who use these services and who are in good physical and reproductive health before pregnancy may still experience complications and even death or disability. The factors that underpin these problems are not explicable or predictable. A study in the United States of America (USA) found that despite intensive screening and antenatal care (ANC) almost 8% of women deemed to have a 'low risk' of complications went on to suffer from serious maternal or fetal complications (Rooks et al, 1989). This is backed up by a study in Zaire that found that only 29% of the cases of obstructed labor could have been predicted based on the patient's obstetric history (Kasongo Project Team, 1987).

### **1.3 Child mortality and morbidity**

Almost 8 million children under the age of five, and 3 million newborns, die every year (Knoll et al, 2010). This represents a global under-five mortality rate of approximately 72 per 1000 live births and a NMR of approximately 30 per 1,000 live births (Murray et al, 2007; Lawn et al, 2005). Similar to maternal mortality, child deaths are not evenly distributed with 99% occurring in developing countries and 28% in sub-Saharan Africa (Lawn et al, 2005). For example, the NMR in sub-Saharan Africa is approximately 44 per 1000 live births compared to 4 per 1000 live births in developed nations (Lawn et al, 2005). Newborn deaths account for 38% of under-five deaths globally and 24% in sub-Saharan Africa (Lawn et al, 2005).

Global under-5 mortality has fallen from approximately 110 per 1000 in 1980 to 72 per 1000 in 2005 representing a decrease in child deaths worldwide from approximately 13.5 million in 1980 to 9.7 million in 2005 (Murray et al, 2007). Globally neonatal mortality has also shown a reduction of 16% between 1996 and 2005 (Lawn et al, 2005). However, similar to maternal mortality trends, these reductions are not replicated in sub-Saharan Africa where NMRs have stayed at the same levels during this period (Lawn et al, 2005). This is particularly true in countries affected by malaria and high HIV prevalence rates where post-neonatal and child mortality are observed to be declining more slowly (WHO, 2006).

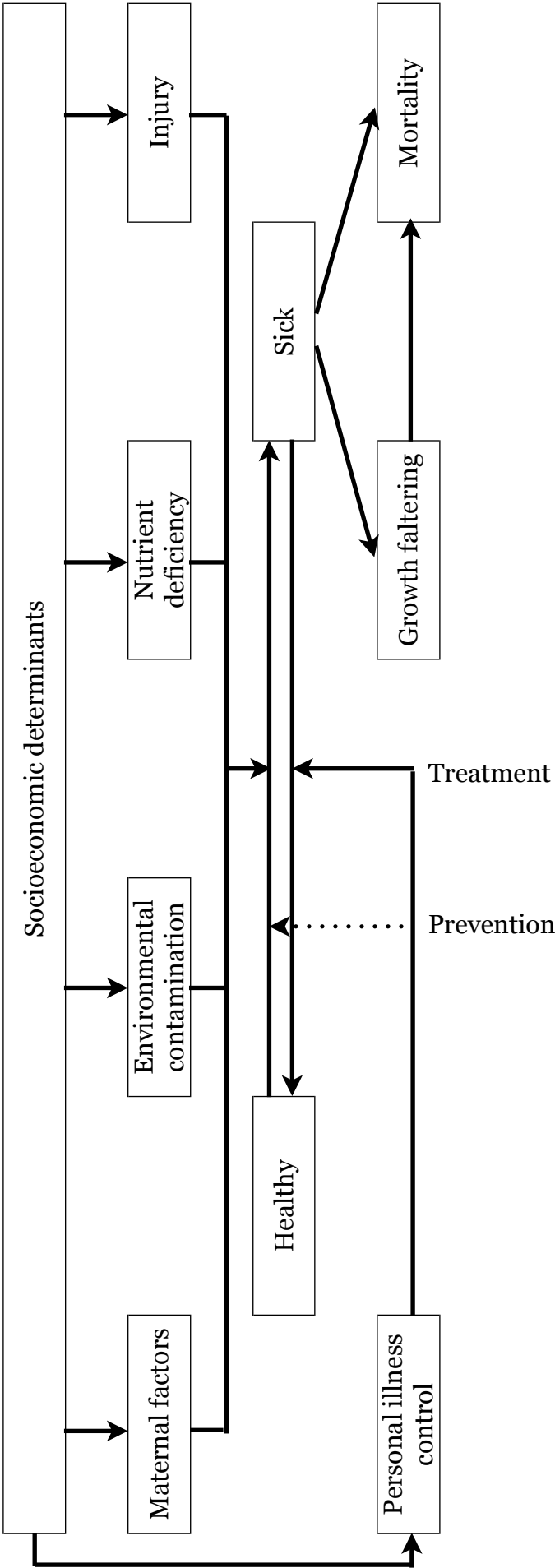
Statistical modeling of direct causes of neonatal death identify preterm birth (28%), sepsis/pneumonia (26%), asphyxia (23%), tetanus and congenital abnormalities (both 7%), and diarrhoea (3%) accounting for most deaths (Lawn et al, 2005). Early neonatal deaths (during the first week of life) are mainly due to complications of pregnancy and childbirth, while later neonatal deaths (in the next three weeks of the neonatal period) are mainly due to infection (Lawn et al, 2005). WHO worldwide estimates for under-fives can be interpolated for causes of death in infants and suggest that the key causes are: pneumonia (19%); diarrhoea (17%); malaria (8%); measles (4%); and HIV/AIDS (3%) (Semba et al, 2008). This information suggests that together, infections such as pneumonia, sepsis, tetanus, HIV/AIDS, diarrhoea,



malaria and measles account for by far the greatest number of neonatal and infant deaths. They also related to other neonatal and child morbidities.

Mosley and Chen (2003) developed a model for the determinants of child survival in developing countries (Figure 1e - 30). The proximate determinants framework describes the dependent variables, child mortality and morbidity, the intermediate variables that directly influence these dependent variables and the social and economic independent variables that indirectly influence child mortality and morbidity by operating through the intermediate variables. The intermediate variables include: maternal factors, environmental contamination, nutrient deficiency, injury, and personal injury control. The first four of these directly operate on the health dynamics of a population by influencing the rate of the shift from health to sickness (Mosley and Chen, 2003). Personal illness control influences the rate of illness (through prevention) and rate of recovery (through treatment) (Mosley and Chen, 2003). The independent variables include: individual level variables such as productivity, traditions, values and norms; household level variables such as income and wealth; and community level variables such as the ecological setting, physical economy and health system (these will be discussed in Section 1.4 below).

Figure 1e: The proximate determinants framework for child morbidity and mortality (Mosley and Chen, 2003)



### **1.3.1 Intermediate variables**

#### **Maternal factors**

Maternal factors exert an independent influence on pregnancy outcomes and infant survival through their effects on maternal health (Mosley and Chen, 2003). These factors are similar to the maternal reproductive characteristics described above for maternal survival. They include: parity, age, and birth spacing (Mahy, 2003). Multiple pregnancies are related to higher rates of stillbirth, prematurity and neonatal death due to complications in pregnancy and childbirth (McDermott et al, 1995). Indeed, the risk of neonatal death is approximately six times higher for multiple births compared to single births (Mahy, 2003). Young mothers have a higher risk of giving birth prematurely and a low birth weight baby and older mothers have a higher risk of giving birth to a baby with congenital abnormalities (Mahy, 2003). Indeed, mothers under the age of 20 and mothers aged between 40 and 49 are respectively 45% and 30% more likely to have their child die in the first month of life (Mahy, 2003). Finally, mothers with birth intervals of less than 24 months are approximately twice as likely to have their infants die in the first month compared to those with birth intervals greater than 24 months (Mahy, 2003).

The women's health status factors mentioned above for maternal survival are also relevant. Of particular note are intra-partum complications such as obstructed labour and malpresentation, which present the highest risks for neonates (Lawn et al, 2005). Maternal infections are also important because although children get most infections during or after birth, some such as syphilis and HIV, can also be acquired from the mother during pregnancy (Hong, 2008). Finally, another key predictor of child survival is whether the mother has died or is too sick to provide adequate care. Studies have shown that infants whose mother died are at higher risk of dying themselves (Campbell et al, 2004). Furthermore, studies in HIV prevalent populations have shown that infants whose mothers are infected with HIV are at higher risk of dying, even when they are not infected themselves (Hong 2008; Nakiyingi et al, 2005).

#### **Environmental contamination**

Environmental contamination refers to the transmission of infectious agents to children. The mechanisms of transmission include: air (respiratory infections and contact diseases); food, water and fingers (diarrhoeas); skin, soil and inanimate objects (skin infections); and insect vectors (parasitic and viral diseases) (Mosley and Chen, 2003).

#### **Nutrient deficiency**

Nutrient deficiency relates to the inadequate intake, by both children and their mothers, of calories, protein and micronutrients. Stunting, severe wasting, and intrauterine growth restriction are among the key problems that can arise. In developing countries almost 60% of deaths of children under 5 are due to malnutrition and its interactive effects on preventable diseases such as sepsis, pneumonia, and diarrhoea (Black et al, 2010). Of these, more than 80%

of deaths related to malnutrition are due to mild-to-moderate rather than severe malnutrition (Black et al, 2010). Furthermore, poor fetal growth as a result of maternal malnutrition, is rarely a direct cause of death, but contributes indirectly to neonatal deaths, particularly those due to birth asphyxia (Black et al, 2010).

## **Injury**

Injury includes accidental physical injuries, intentional injuries, burns, drowning, poisoning and other hazards. Data on injuries is not widely available for developing countries. However a report on the problem in developed countries found that injury accounts for almost 40% of annual deaths in children aged 1 to 14 (Roach, 2001). Although accidental injuries are generally random events, their frequency and pattern in a population is a reflection of the environmental risks which are distributed according to socioeconomic, cultural and environmental contexts (Mosley and Chen, 2003).

## **Personal illness control**

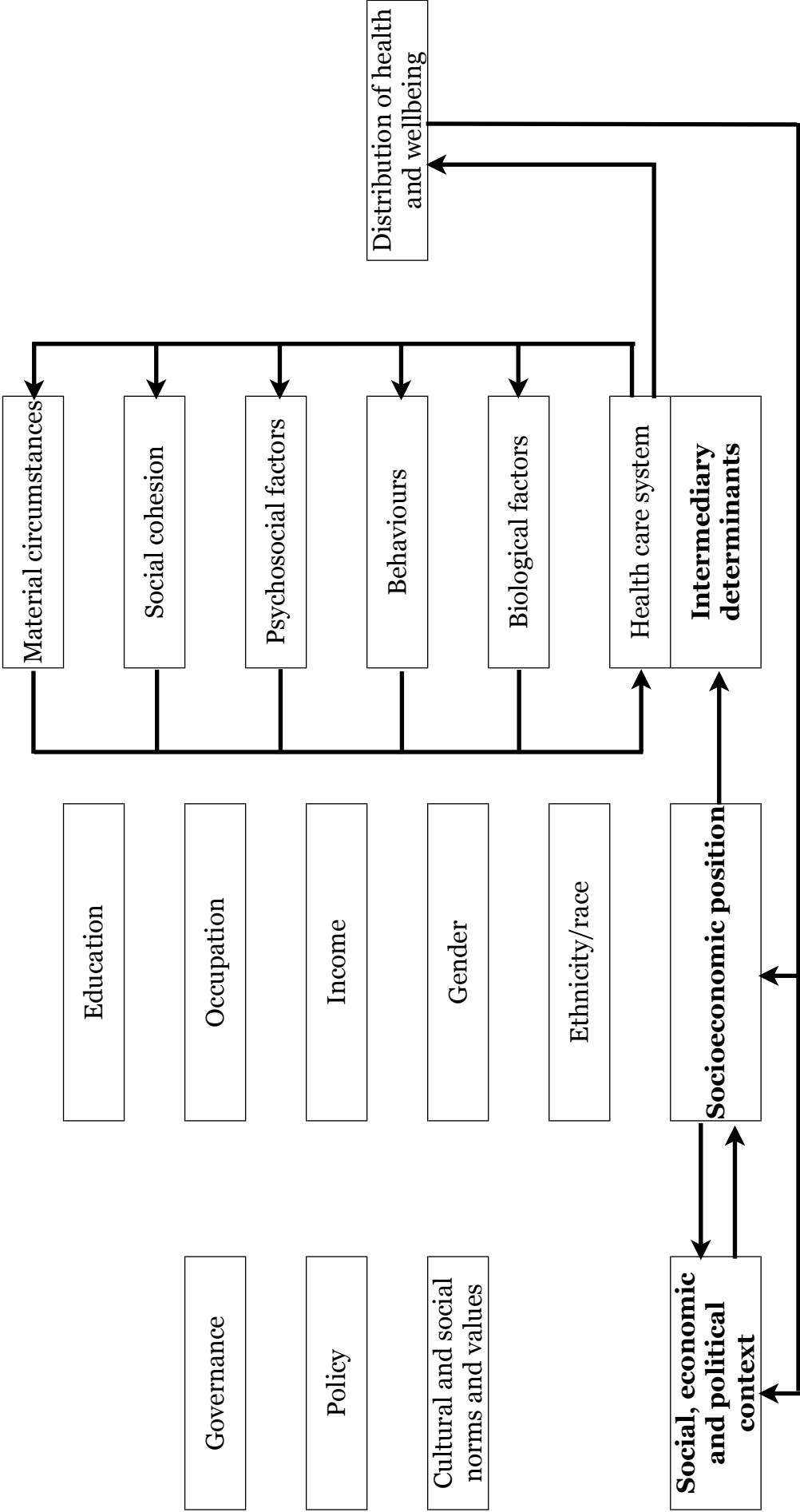
Personal illness control refers to the behaviours that healthy individuals practice to avoid disease as well as the behaviours that sick individuals practice to treat diseases. Similar to the maternal health care behaviours described above these include both child care and child care seeking behaviours. In terms of care-seeking behaviours skilled birth attendance and facility delivery and health care seeking in the event of child illness are particularly relevant. Indeed, skilled attendance and facility delivery rates are lowest in the countries with the highest rates of neonatal mortality (WHO, 2007). Furthermore, there is evidence that neonatal tetanus is more common where maternal immunisation rates are low (Lawn et al, 2005). In terms of care behaviours those for newborns are particularly key because they can lead to infection. For example, sepsis commonly arises from unhygienic cord care practices and diarrhoea from unhygienic feeding practices. Another example is malaria which in children can be prevented by intermittent presumptive treatment of malaria in pregnancy, chemoprophylaxis and use of insecticide-treated nets (ITN) (Steketee et al, 2001). A final example, includes cultural norms relating to cord care, wrapping and bathing practices, use of colostrums and when and what other foods are introduced. Many of these have been qualitatively linked to neonatal mortality (Morrison et al, 2005).

### **1.4 Distant factors and independent variables**

Disorders and diseases are often considered to result from individual 'lifestyle choices' (Irwin et al, 2006). However, these choices are conditioned by patterns of material deprivation and social exclusion and are thus disproportionately concentrated in socially disadvantaged groups, both in developed and developing countries (Gupta et al, 1994). As a result although good medical care and changes in lifestyle are essential, they are not sufficient, for meeting the major health challenges and overcoming the health inequalities facing populations today (Irwin et al,

2006). Research suggests that the social conditions in which people live and work account for a far greater share of these health problems (Marmot and Wilkinson, 1999; Tarlov, 1996; McGinnis et al, 2002). Indeed, throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, get sicker, and die earlier than people in more privileged social positions (Irwin et al, 2006). Ultimately the poorest of the poor, around the world, have the worst health (CSDH, 2008). For this reason the maternal and child morbidity and mortality determinant frameworks presented above also include socioeconomic variables (called distant factors in the McCarthy and Maine (1992) framework and independent variables in the Mosley and Chen (2003) framework) that indirectly influence mortality and morbidity through the intermediate factors and variables in these frameworks. The Commission on the Social Determinants of Health (CSDH) developed a conceptual framework describing the key socioeconomic and political factors that are thought to underly poor health (Figure 1f - page 34).

Table 1f: SDH framework (Solar and Irwin, 2010)



This framework illustrates how the social and political contexts within which people live generate social, economic and political mechanisms which stratify society. This stratification can be described by a set of socioeconomic positions which in turn shape specific determinants of health status. The social and political contexts include all social and political mechanisms that generate, configure and maintain social hierarchies, including: the labour market; the educational system, political institutions and other cultural and societal values (Solar and Irwin, 2010). Proxy measures for the socioeconomic positions include: social class, ethnicity, education, occupation and income. Together the social and political context and resultant socio-economic positions are termed 'structural determinants' of health.

These social determinants operate through a set of intermediary determinants of health to shape health outcomes some of which have already been discussed as intermediate factors (section 1.2.2) and variables (section 1.3.1) in the two models of health determinants presented above. They include: material circumstances (including factors such as housing and neighborhood quality, consumption potential and the physical work environment), psychosocial circumstances (including psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles), social cohesion, behavioral and biological factors (including nutrition, physical activity, and genetic factors), and the health system itself.

The socioeconomic factors described in the social determinants model (Figure 1f - page 34) are often differentiated into individual, household or family, and community level factors. For maternal mortality and morbidity, at an individual level, the main factors that influence health may include: educational level, occupation, gender equity, ethnicity, personal income and wealth, autonomy and social status, literacy, attitudes, norms and values, etc. At a family or household level the main factors may include: family income, land, decision-making power, occupation and education of family members, etc. At a community level the main factors may include: aggregate resources and wealth, social cohesion, security, governance, policy, vulnerability to natural disasters, etc. There is considerable evidence to support the links between these poverty factors and higher risk of maternal deaths (Ronsmans et al, 2006). For example, a study by Gupta et al (2010) in Rajasthan found evidence of a direct link between poverty and increased risk of maternal deaths. The study showed that risk of death was nearly five times higher among women who belonged to poor households and attributed this predominantly to inadequate access, utilization, and quality of ANC and delivery services (Gupta et al, 2010).

For child morbidity and mortality the main factors may include: individual productivity and attitudes, norms and values at the individual level; income and wealth at the family and household level; and ecological setting, political economy and the health system at the community level (Mosley and Chen, 2003). These associations between poverty and child

deaths have been made since the 1940s when Titmuss (1943) linked children's deaths to the occupations of their fathers and showed that the gap between the life chances of working class and middle class infants had increased since 1914. For example, research has shown that a child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest social class (Woodroffe et al, 1993). Another example comes from a study of national-level data from 152 countries which showed that GNI/capita, young female illiteracy, and income equality predicted 92% of the variation in national IMRs (Schell et al, 2007). In a third example, a study of health related quality of life of children found that a higher parental educational status and family wealth had a significant positive impact on: physical wellbeing, psychological wellbeing, moods and emotions, bullying and perceived financial resources (von Rueden et al, 2006). Another example posits that social exclusion is an aspect of poverty and has adverse psychosocial effects. Roberts et al (1997) showed that emotional problems that arise from social exclusion in childhood affect many aspects of health and behaviour in adult life. Finally, poor children are thought to be more likely to die as they are more likely to be exposed to disease, are less likely to receive preventive interventions, are more likely to acquire disease, have lower resistance to disease, have lower access to health facilities, are less likely to be managed appropriately in health facilities, are less likely to get lifesaving drugs and have lower access to secondary and tertiary care (Victora et al, 2003; Gwatkin et al, 2005; Wagstaff et al, 2004).

The relationship between social determinants and health suggests that they must be addressed to achieve MCH related targets. Furthermore, efforts to address these underlying social conditions, which make people who are disadvantaged more vulnerable, need to take place at both the policy and programming level.

## **1.5 Approaches to improve MCH and reduce mortality**

The 1990 United Nations Summit on the Millennium Development Goals (MDGs) concluded with the adoption of a global action plan to achieve eight anti-poverty goals by 2015. Two of these MDGs were concerned specifically with MCH. MDG four, to reduce the mortality rate of children under five by two-thirds; and MDG five, to reduce the MMR by three-quarters and to achieve universal access to reproductive health.

Many effective maternal, newborn and child health interventions with the potential to achieve these targets already exist although they are often not available to the poorest mothers and children who also experience the highest levels of mortality (Lawn et al, 2005; Ronsmans et al, 2006; Victora et al, 2003). Indeed reviews of effective maternal and neonatal health interventions have shown that, if universal coverage of these known interventions is achieved, they have the potential to reduce maternal mortality by 74% and neonatal mortality by 41% to 72% (Darmstadt et al, 2005; Victora et al, 2003). Furthermore, effective under-five health



interventions, again at universal coverage, have the potential to reduce child mortality by 66% (Bryce et al, 2005). In 2011 the Partnership for Maternal, Neonatal and Child Health (PMNCH) reviewed and recommended the most effective of these interventions and recommended that they should included as integrated programmes provided through a continuum of care approach (Table 1g - page 38 to 41).

Table 1g: Essential, evidence-based interventions to reduce reproductive, maternal, newborn and child mortality, and promote reproductive health (PMNCH, 2011)

	<b>Adolescence and pre-pregnancy</b>	<b>Pregnancy (antenatal)</b>	<b>Birth</b>	<b>Postnatal (mother)</b>	<b>Postnatal (Newborn)</b>	<b>Infancy and childhood</b>
<b>Community primary referral</b>	<ul style="list-style-type: none"> <li>•Family planning (advice, hormonal and barrier methods)</li> <li>•Prevent and manage sexually transmitted infections, HIV</li> <li>•Folic acid fortification/ supplementation to prevent neural tube defects</li> </ul>	<ul style="list-style-type: none"> <li>•Iron and folic acid supplementation</li> <li>•Tetanus vaccination</li> <li>•Prevention and management of malaria with ITNs and antimalarial medicines</li> <li>•Prevention and management of sexually transmitted infections and HIV, including with antiretroviral medicines</li> <li>•Calcium supplementation to prevent hypertension (high blood pressure)</li> <li>•Interventions for cessation of smoking</li> </ul>	<ul style="list-style-type: none"> <li>•Prophylactic uterotonics to prevent postpartum haemorrhage (excessive bleeding after birth)</li> <li>•Manage postpartum haemorrhage using uterine massage and uterotonics</li> <li>•Social support during childbirth</li> </ul>	<ul style="list-style-type: none"> <li>•Family planning advice and contraceptives</li> <li>•Nutrition counseling</li> </ul>	<ul style="list-style-type: none"> <li>•Immediate thermal care (to keep the baby warm)</li> <li>•Initiation of early breastfeeding (within the first hour)</li> <li>•Hygienic cord and skin care</li> </ul>	<ul style="list-style-type: none"> <li>•Exclusive breastfeeding for 6 months</li> <li>•Continued breastfeeding and complementary feeding from 6 months.</li> <li>•Prevention and case management of childhood malaria</li> <li>•Vitamin A supplementation from 6 months of age</li> <li>•Routine immunization plus H.influenzae, meningococcal, pneumococcal and rotavirus vaccines</li> <li>•Management of severe acute malnutrition</li> <li>•Case management of childhood pneumonia</li> <li>•Case management of diarrhoea</li> </ul>

	Adolescence and pre-pregnancy	Pregnancy (antenatal)	Birth	Postnatal (mother)	Postnatal (Newborn)	Infancy and childhood
<b>Primary and referral</b>	<ul style="list-style-type: none"> <li>•Family planning (hormonal, barrier and selected surgical methods)</li> </ul>	<ul style="list-style-type: none"> <li>•Screening for and treatment of syphilis</li> <li>•Low dose aspirin to prevent</li> <li>•pre-eclampsia (high blood pressure)</li> <li>•Antihypertensive drugs (to treat high blood pressure)</li> <li>•Magnesium sulphate for pregnancy- induced eclampsia (high blood pressure)</li> <li>•Antibiotics for preterm/pre-labour rupture of membranes</li> <li>•Corticosteroids to prevent respiratory distress syndrome in newborns</li> <li>•Safe abortion, where legal</li> <li>•Post abortion care</li> </ul>	<ul style="list-style-type: none"> <li>•Active management of third stage of labour (to deliver the placenta) to prevent postpartum haemorrhage (as <i>above plus controlled cord traction</i>)</li> <li>•Management of postpartum haemorrhage (as <i>above plus manual removal of placenta</i>)</li> </ul>	<ul style="list-style-type: none"> <li>•Screen for and initiate or continue antiretroviral therapy for HIV (family planning advice, contraception)</li> <li>•Treat maternal anaemia</li> </ul>	<ul style="list-style-type: none"> <li>•Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth)</li> <li>•Kangaroo mother care for preterm (premature) and for less than 2000g babies</li> <li>•Extra support for feeding small and preterm babies</li> <li>•Management of newborns with jaundice (“yellow” newborns)</li> </ul>	<ul style="list-style-type: none"> <li>•Comprehensive care of children infected with or exposed to HIV infection</li> </ul>

	Adolescence and pre-pregnancy	Pregnancy (antenatal)	Birth	Postnatal (mother)	Postnatal (Newborn)	Infancy and childhood
<b>Referral</b>	<ul style="list-style-type: none"> <li>Family planning (surgical methods)</li> </ul>	<ul style="list-style-type: none"> <li>Reduce malpresentation at term with External Cephalic Version (Align the baby for safe delivery)</li> <li>Induction of labour to manage pre-labour rupture of membranes at term (Initiate delivery)</li> </ul>	<ul style="list-style-type: none"> <li>Caesarean section for absolute maternal indication (to save the life of the mother)</li> <li>Prophylactic antibiotic for caesarean section</li> <li>Induction of labour for prolonged pregnancy (Initiate labour)</li> <li>Management of post-partum haemorrhage (as above plus surgical procedures)</li> </ul>	<ul style="list-style-type: none"> <li>Detect and manage postpartum sepsis (serious infections after birth)</li> </ul>	<ul style="list-style-type: none"> <li>Presumptive antibiotic therapy for newborns at risk of bacterial infection</li> <li>Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies</li> <li>Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome</li> <li>Case management of neonatal sepsis, meningitis and pneumonia</li> </ul>	<ul style="list-style-type: none"> <li>Case management of meningitis</li> </ul>

	<b>Adolescence and pre-pregnancy</b>	<b>Pregnancy (antenatal)</b>	<b>Birth</b>	<b>Postnatal (mother)</b>	<b>Postnatal (Newborn)</b>	<b>Infancy and childhood</b>
<b>Community strategies</b>	<ul style="list-style-type: none"> <li>•Home visits for women and children across the continuum of care</li> <li>•Women's groups</li> </ul>					

The majority of these interventions seek to address the intermediate factors and outcomes that have a direct impact on maternal and child morbidity and mortality. However, a small subset of these interventions - women's groups, or defined more explicitly, community mobilisation interventions - seek to specifically influence the SDH, as well as the intermediate factors and outcomes. All types of approaches are useful (Filippi et al, 2006; Bhutta et al, 2010). For example, universal access to maternal healthcare (births are attended by skilled birth attendants who are able to prevent, manage and refer women with obstetric complications) is seen as the starting point to achieve MDG 5. However, community-based action is essential to ensure universal access to maternal healthcare and has shown great promise with significant increases in uptake of services (Manadhar et al, 2004).

## **1.6 Thesis overview**

Chapter 2 defines community mobilisation, highlights that it has become a catchall term and that not all interventions defined as such actually seek to address the SDH. In this chapter, the subset of community mobilisation interventions that do seek to address the SDH are identified as those that specifically seek to empower communities. The literature is reviewed to identify and describe these specific interventions.

Chapter 3 defines community empowerment. It also reviews the literature to show that there is little or no evidence about the socio-environmental mechanism through which these interventions empower communities to address the SDH and therefore improve MCH and reduce mortality. In this chapter the women's group intervention delivered by MaiMwana Project in Mchinji District, Malawi, is identified as an opportunity to surface this mechanism. Furthermore, theories of mechanism in critical realism are presented.

Chapter 4 describes the MaiMwana women's group intervention in Mchinji district, Malawi. It also presents the grounded theory methodology and the observation and focus group discussion (FGD) data collection and sampling methods employed in this thesis, to surface the socio-environmental mechanism through which it is addressing the social determinants of MCH and therefore improving MCH and reducing mortality.

Chapters 5, 6 and 7 present the results of the thesis. Chapter 5 presents evidence of how women's group members have become more organised and mobilised to take action to address the social determinants of MCH. Chapter 6 presents evidence of the capacities built by the MaiMwana women's group intervention, in women's group members, to organise and mobilise themselves to take action. Chapter 7 presents evidence of the interpersonal resources and relationships that have been generated through women's group members becoming more organised and mobilised to take action.

Chapter 8 presents an interpretation of the findings of the thesis and presents the socio-environmental mechanism through which the MaiMwana women's group intervention addresses the SDH and thus improves MCH and reduces mortality - **the MaiMwana women's group intervention improves MCH and reduces mortality by building the capacities of women's group members to organise and mobilise, empowering them to harness the interpersonal elements that arose from this process and bring them to bear on the social determinants of MCH through individual, organisational and community action.** The limitations of the study, recommendations for the MaiMwana women's group intervention and implications for future research are also considered.

## **1.7 Thesis aims and objectives**

### **1.7.1 Aim**

This thesis is concerned with surfacing the socio-environmental mechanism through which community mobilisation approaches improve health and reduce mortality.

### **1.7.2 Objectives**

To achieve the aim, this thesis will explore how the MaiMwana women's group intervention in Mchinji District, Malawi, enables communities to take control of the SDH and thus reduce maternal and child morbidity and mortality. More specifically:

- To describe the activities provided by the MaiMwana women's group intervention
- To explore the capacities built by the intervention to help community members to organise and mobilise themselves to take action to improve MCH and reduce mortality
- To explore how community members organise and mobilise themselves to take action to improve MCH and reduce mortality
- To explore the interpersonal resources and relationships generated as the community members organise and mobilise themselves and that they can draw on to take action to improve MCH and reduce mortality

## **Chapter 2: Community mobilisation**

### **2.1 Health promotion**

There are a number of different approaches to promote health. These include population health, disease prevention, health protection, harm reduction and health promotion approaches. Health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter for Health Promotion, 1986). It can be differentiated from other approaches to health through five key features (Ontario Health Promotion Resource System, 2012):

1. Health promotion takes a holistic view of health
2. Health promotion employs participatory approaches
3. Health promotion focuses on the determinants of health
4. Health promotion builds on existing strengths and assets rather than adjusting health problems and deficits
5. Health promotion uses multiple and complementary strategies to promote health at the individual and community level

#### **2.1.1 Holistic view of health**

The WHO defines health as “a positive concept”, “a state of complete physical, mental and social wellbeing rather than a mere absence of disease or infirmity” and thus as “a resource for everyday life not just the objective of living”. The health promotion approach adopts the same holistic definition. It can be conceptualised as the process of reaching this state of complete physical, mental and social wellbeing, by enabling individuals or groups to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment (Ottawa Charter for Health Promotion, 1986).

#### **2.1.2 Participatory approaches**

Health promotion employs participatory approaches that seek to address health issues with people rather than for people. This promotes empowerment by enabling people to gain greater control over conditions affecting their health; social justice and equity by ensuring that everyone has equitable access to those factors needed to maintain good health; involvement and participation by ensuring that everyone has a voice in decisions affecting their health; and it promotes respect for all different perspectives on health.

#### **2.1.3 Determinants of health**

Three explanatory models of health have emerged over time: the medical model; the behavioural / lifestyle model; and the socio-environmental model. The medical model views health as the absence of diseases or disorders. For example, maternal mortality in developing countries is caused by: haemorrhage, sepsis and hypertensive disorders. In this model, health

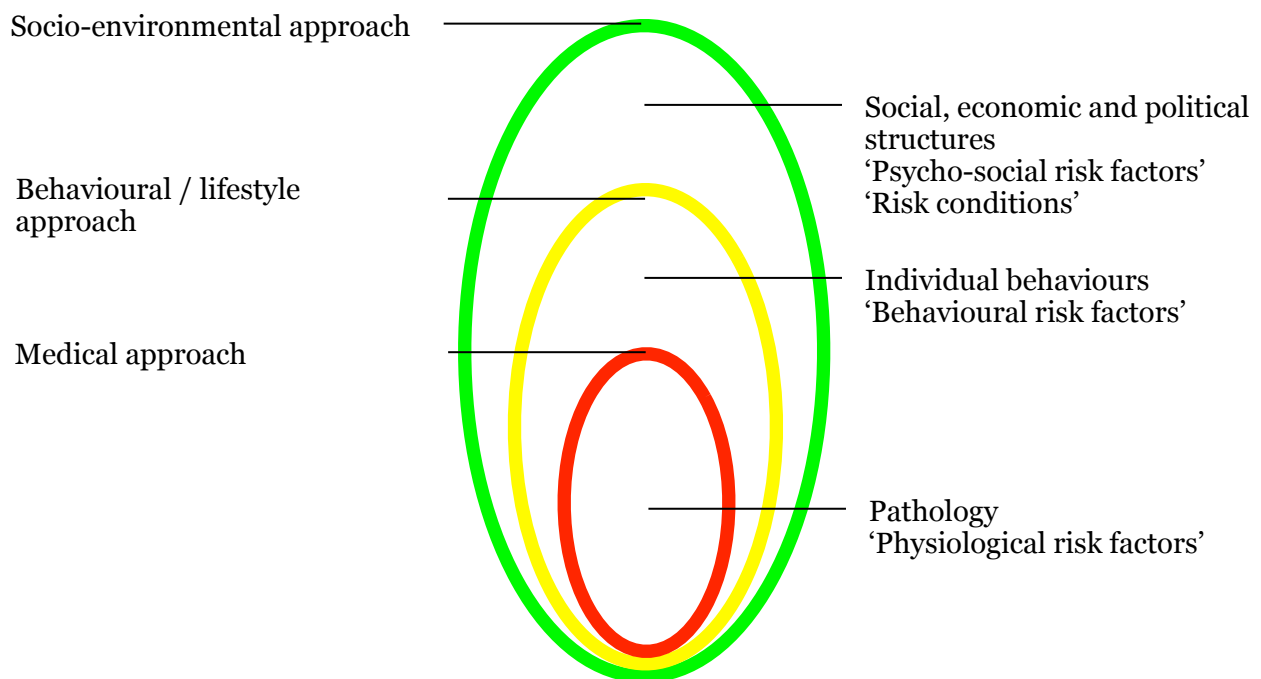


is determined by these 'physiological risk factors'. The behavioural / lifestyle model views health as the product of healthy lifestyle choices. For example, maternal mortality in developing countries is caused by: unhygienic delivery practices, delivery with an unskilled attendant and lack of birth preparedness. In this model, health is determined by these 'behavioural risk factors'.

The socio-environmental model views health as the product of multiple and interrelated social, economic and environmental factors that in combination determine the health status of individuals and populations by providing incentives and barriers to the health of individuals and communities (Nutbeam, 1998). For example, as discussed in chapter 1, maternal and child mortality in developing countries are caused by: poverty, social isolation and powerlessness. In this model, health is determined by these 'risk conditions' and 'psychosocial risk factors'.

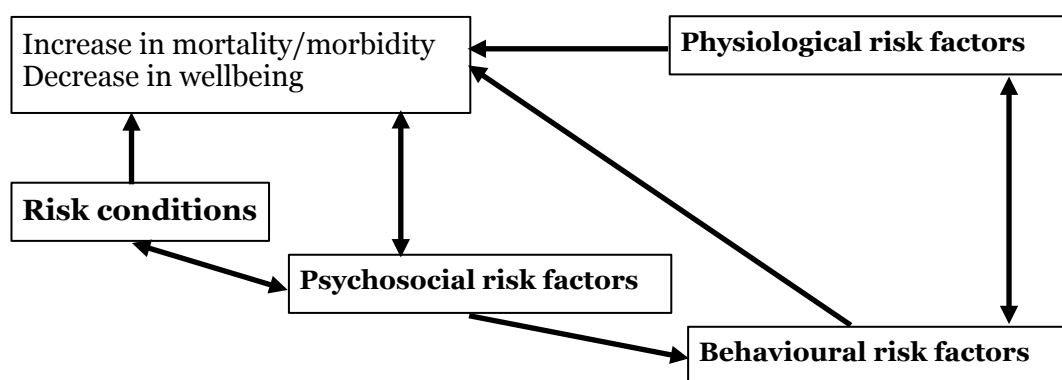
Laverack (2004) argued that although the three models exist as independent health discourses their distinctions also blur and they can be conceptualised as a Russian doll, one inside the other, rather than totally separate ways of thinking (figure 2a - page 46). "The medical approach, the most precise definition, occupies the smallest doll. The behavioural approach incorporates the medical approach within a slightly larger doll that includes 'space' for individual behaviours and social norms that shape them. The socio-environmental approach incorporates both the behavioural and the medical in the largest doll, whose new 'space' is cluttered with all the social, economic and political structures that shape not only individual lifestyles but also people's risks of disease or opportunities for wellbeing" (Laverack, 2004).

*Figure 2a: The three explanatory models of health*



Frameworks of health determinants have been proposed that link higher disease burdens, higher rates of premature death and lower levels of wellbeing to these 'risk factors' and 'risk conditions' (figure 2b - page 48) (Wilkinson 2003; Labonte 1993, 1998). Risk conditions are those living and working conditions that are deeply structured by economic and political practices and by dominant ideologies and discourses (e.g. poverty, low social status, steep power hierarchies, etc). People are thought to internalise the unfairness of their social circumstances as aspects of their own 'failure' thereby increasing their psychosocial risk factors (e.g. isolation, lack of social support, lack of awareness, lack of motivation to change, etc), which are also associated with increased mortality, higher disease burden and lower levels of wellbeing (Labonte 1993; 1998). Psychosocial risk factors are those individual cognitive or emotional states which are often reactions to risk conditions and which also influence our desire and ability to create social networks and support systems. These psychosocial risk factors in turn lead to behavioural risk factors (e.g. risky sexual practices, poor nutrition, etc), which are again associated with increased mortality, higher disease burdens and lower levels of wellbeing. All of this increases health threatening physiological risk factors, which also lead to increased mortality, higher disease burdens and lower levels of wellbeing.

Figure 2b: The determinants of health (Labonte 1993, 1998)



Traditionally, health promotion has tended to follow a medical or behavioural / lifestyle approach and focused on physiological and behavioural risk factors. Contemporary health promotion defined health according to the socio-environmental approach and has an expanded focus on the underlying ‘risk conditions’ and ‘psychosocial risk factors’ that determine health status of individuals and communities.

#### **2.1.4 Building on existing strengths and assets**

Health promotion approaches focus on strengths and assets of individuals and communities and build on positive factors promoting the health of individuals and communities. This differentiates it from other approaches such as ‘disease prevention’ and ‘population health’, which focus on the eradication and elimination of negative factors – problems, health risks and deficits – that contribute to illness and poor health outcomes.

#### **2.1.5 Multiple complementary strategies**

The Ottawa Charter for Health Promotion (1986) identified five key action areas for health promotion practice:

1. Building healthy public policy: by raising awareness of policy makers of the health consequences of their decisions and by encouraging them to take responsibility for health.
2. Creating supportive environments: by encouraging reciprocal maintenance – communities and environments taking care of each other.
3. Strengthening community action: empowering communities, their ownership and control of their own endeavours and destinies by involving them in setting priorities, making decisions, planning strategies and implementing them to achieve better health.
4. Developing personal skills: supporting personal and social development by providing information, education for health and enhancing life skills so people can take control of and make effective choices regarding their health.
5. Reorienting health services: encouraging health services to embrace and integrate health promotion into their practice so they can support the needs of individuals and communities for a healthier life.

A number of health promotion methods are employed in these action areas. The health promotion approach encourages the use of several of these complementary methods in parallel:

- Health communication: is “the use of communication techniques to positively influence individuals, populations and organisations for the purposes of promoting conditions conducive to human and environmental health” (Nutbeam, 1998).
- Health education: is “the principle by which individuals and groups of people learn to behave in a manner conducive to the promotion, maintenance, or restoration of health” (Simons-Morton et al, 1995).
- Self-help / mutual aid: is “the process by which people who share common experiences, situations or problems can offer each other a unique perspective that is not available for

those who have not shared these experiences” (Self-help Resource Centre of Greater Toronto, 1996).

- Organisational change: is “the process of working within these settings [the settings and environments within which people spend their time] to create supportive environments that better enable people to make healthy choices” (Nutbeam, 1998).
- Community mobilisation: is “a capacity-building process through which community individuals, groups, or organisations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others” (Howard-Grabman and Snetro, 2003).
- Advocacy: is “the pursuit of influencing outcomes — including public-policy and resource allocation decisions within political, economic, and social systems and institutions — that directly affect people’s lives. Therefore, advocacy can be seen as a deliberate process of speaking out on issues of concern to exert some influence on behalf of ideas or persons” (Cohen, 2001).
- Policy development: “healthy public policy encompasses legislation, taxation, fiscal measures and organisational change initiatives. Healthy public policies promote the health of individuals and communities by: making it easier for people to adopt healthy practices; making it harder for people to adopt unhealthy practices; and creating healthy physical and social environments” (Nutbeam, 1998).

The three models of health presented above represent different ways of achieving better health. In doing so they employ different health promotion methods to address the health issues faced (table 2c - page 51).

*Table 2c: Models of health, determinants of health and strategies*

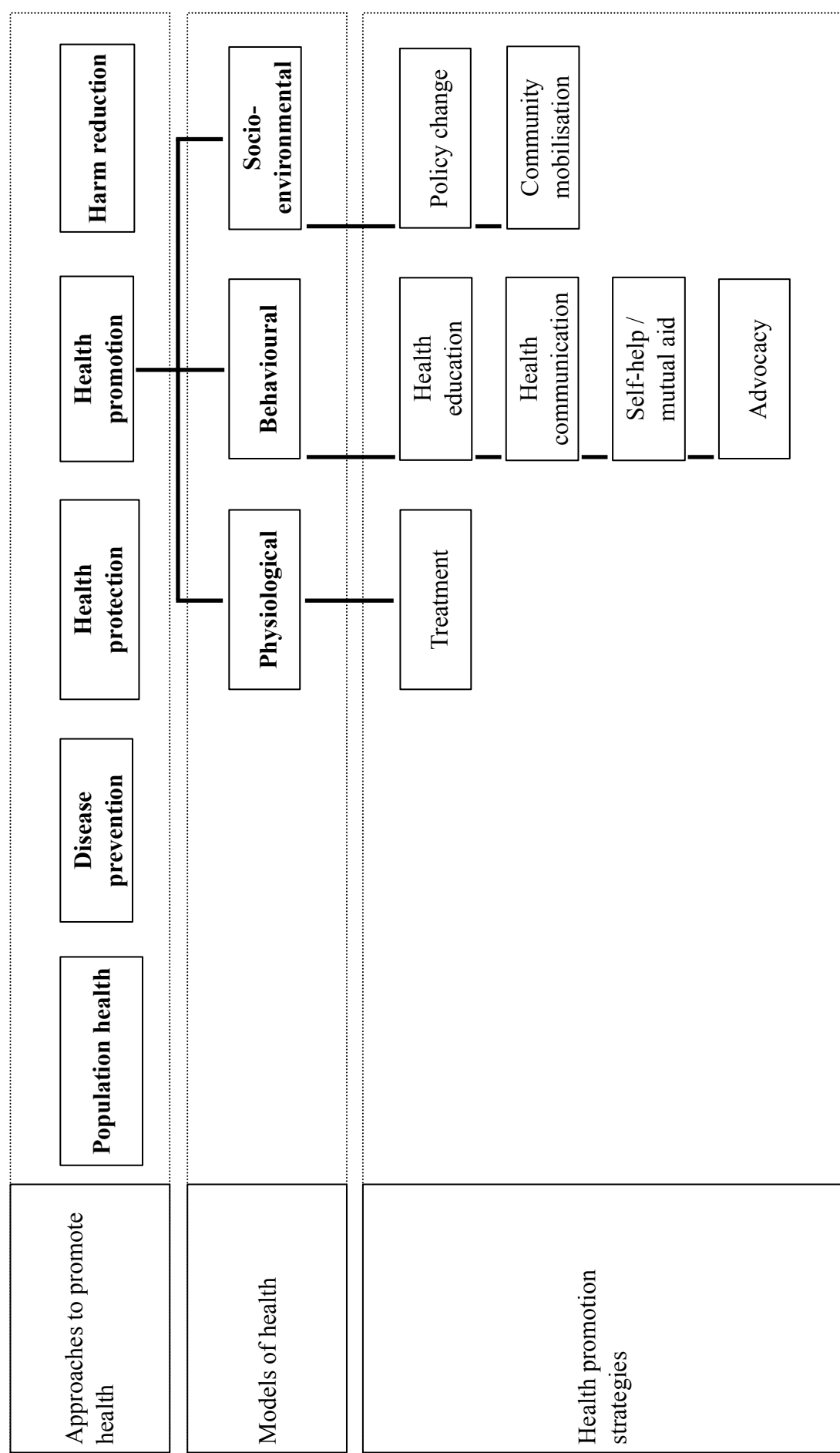
<b>Model of health</b>	<b>Determinants of health status</b>	<b>Methods</b>
Medical model	Physiological risk factors	<ul style="list-style-type: none"> <li>• Treatment</li> </ul>
Behavioural / lifestyle model	Physiological risk factors PLUS Behavioural risk factors	<ul style="list-style-type: none"> <li>• Treatment PLUS</li> <li>• Health education</li> <li>• Health communication</li> <li>• Self-help / mutual aid</li> <li>• Advocacy for health public policies supporting lifestyle choices</li> </ul>
Socio-environmental model	Physiological risk factors Behavioural risk factors PLUS Psychosocial risk conditions Risk factors	<ul style="list-style-type: none"> <li>• Treatment PLUS</li> <li>• Health education</li> <li>• Health communication</li> <li>• Self-help / mutual aid</li> <li>• Advocacy PLUS</li> <li>• Policy change</li> <li>• Community mobilisation</li> </ul>

## **2.2 Community mobilisation**

The above exploration of the family history of community mobilisation reveals a number of key characteristics (figure 2d - page 53). First, it reveals that community mobilisation is one method for improving health amongst a range of other methods. Second, it suggests that community mobilisation has characteristics of the socio-environmental model of health viewing it not simply as the result of physiology and behaviour but also as the product of multiple and interrelated social, economic and environmental factors. Third, it suggests that community mobilisation has characteristics of the health promotion approach in that it: views health holistically; is a participatory approach; builds on existing strengths and assets; and is most effective when used in parallel to other complementary sibling methods. Finally, it suggests that community mobilisation has, at its root, the shared health promotion values of: empowerment; social justice and equity; inclusion in decision-making; and respect for diversity.



Figure 2d: The community mobilisation family tree



This linear discussion of community mobilisation from approaches to models and strategies suggests that it is a single discrete method for promoting better health. However, as it has evolved it has itself created a broad range of forms with divergent characteristics. This situation is further confused because while some of these new formulations have retained the term community mobilisation others have new names such as: community readiness; community involvement; community participation; community competence; community engagement; community organisation; community development; community capacity; community control; community action; and community empowerment. Often different people are using different terms to mean the same thing (Labonte and Reid, 1997). However, all these concepts are essentially different forms of social and organisational mobilisation that seek to address inequalities in the lives and health of community members (Laverack, 2007). They are different forms of community mobilisation that can be distinguished using a 'ladder of community-based interaction' (figure 2e - page 55), which depicts them as a dynamic continuum (Laverack 2007).

Figure 2e: The ladder of community-based interaction



On the simplest level these forms can be grouped into those concerned with participation - involving an interaction between people but not a commitment towards achieving a goal, those concerned with action - involving the identification, planning and resolution of community concerns through specified goals and actions - and those concerned with empowerment - involving a sense of struggle and liberation bound in the process of capacity building and gaining power (Laverack, 2007). Forms higher on the continuum involve greater social and organisational interaction and make community members more concerned about and ready to address the SDH.

Community mobilisation is thus a family of methods that range along a continuum rather than a single all-embracing method. Although these different methods are contrasting and sometimes clashing formulations they overlap and, to a greater or lesser extent, all share characteristics drawn from their health promotion lineage. As a result, it is possible to adopt a general definition for this family of strategies. In this thesis the following definition has been adopted: “Community mobilisation is a capacity-building process through which community individuals, groups, or organisations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others” (Howard-Grabman and Snetro, 2003).

### **2.2.1 Different conceptual frameworks for community mobilisation**

Having the above general definition of the community mobilisation family is useful but of limited value. First, the definition wrongly suggests that there is a single conceptualisation that embraces all forms of the method. Second, the proliferation of formulations and the parallel proliferation of terms to describe these formulations is confusing for academics and programmers. As Taylor and Roberts (1985) state about community organisation theory: “eclecticism, pragmatism and practice wisdom of professionals fosters a turbulence and diversity that makes categorization and model building especially difficult tasks”. Simply lumping these concepts together under one definition does not address these issues. Finally, it leads to the assumption that it is adequate simply to evaluate all community mobilisation interventions without a detailed consideration of exactly what form of intervention is being evaluated. This often results in contradictory and confusing findings and a lack of clarity and confidence over the effectiveness of these interventions.

As a result, there is need to provide clarity to the community mobilisation method by capturing and describing its different forms. This helps to differentiate the components that are critical to the different forms; and it helps practitioners understand what they are doing and why (Weil and Gamble, 2005). A number of different frameworks have been developed that can help to achieve this and are presented below.

### **Rothman (1968; 1995) and Rothman and Tropman (1970)**

Originally formulated by Rothman (1968) and then further expanded by Rothman and Tropman (1970) and Rothman (1995) this is the first and most widely recognised framework. It consists of three categories of forms of deliberate or purposive community intervention: the social planning forms; the locality development forms and the social action forms (Rothman, 1968). These categories are differentiated by the goals they seek to achieve, the roles assigned to and conceptions of external agents and the community itself and the change strategies and tactics they seek to employ.

The social planning forms are oriented to rationally solving substantive community problems that exist in the community – task goals. They view the community as a passive recipient or consumer of services that are developed through the social planning process, which is carried out by external experts. These professionals gather facts about the problems in the community, analyse these problems, make decisions about the most rational course of action and implement these solutions. “Opportunities for members and consumers to determine policy are severely limited because they are not usually organised for this purpose” (Morris et al, 1966).

The locality development forms are oriented to building community capacity, integration and identity and thus promoting self-help – process goals. They consider the problems affecting the community to result from its fractured and isolated nature and lack of relationships, decision-making skills and democratic processes. The community is viewed as a real participant in a common interactional problem solving process which involves a broad cross-section of people coming together in small-groups and determining their own problems and implementing their own solutions. External agents act as enablers and catalysts to this process and in particular develop problem solving skills.

The social action forms are oriented to changing power relations as well as pursuing more specific small-scale outcomes – task and process goals. “Organizing has both short- and long-range benefits. In the short run its an effective tool for getting things done...But it is also an end in itself. As we organise, we clarify ourselves as individuals because we learn to speak for ourselves in ways that make us heard” (Kahn, 1982). The problems facing the community are considered to result from a hierarchy of privilege and power that leads to clusters of the population being disadvantaged and suffering from social injustice, deprivation and inequality. The community is viewed as the leader of the process and the external agent is an activist advocate, agitator and broker for the community - an employee or servant of the people. The process of change involves the marginalised and oppressed groups in the community coming together to crystallize their issues and organise to take action by targeting, confronting and taking direct action against the larger, oppressing, society.

The authors highlighted that although most forms of community intervention fall within one of the three categories in reality these orientations are overlapping rather than discrete and are used in mixed form in practice (Rothman and Tropman, 1987; Rothman, 1995). As a result, besides the three pure categories described above there are also three categories of 'bimodal mixtures' (development/action, planning/development and action/planning) and a category of mixed interventions that includes a cross section of variables from all three pure categories.

### **Labonte (1992; 1993)**

Labonte (1992; 1993) developed a framework that distinguishes between two categories of forms of community development: community-based strategy forms; and community development strategy forms. These categories are differentiated by who sets the agenda and who names the issue or problem (Labonte, 1997).

Community-based strategy forms are useful approaches in public health and involve bringing institutional programmes into community settings to address specific diseases, lifestyle behaviours and public policies that influence risk (Labonte, 1993; Labonte and Robertson, 1996). These forms represent a biomedical and disease prevention orientation to health promotion (Labonte, 1993). In these forms external agents identify and define the problems affecting individuals and groups and develop strategies to address these problems that focus on changing behaviours, and/or education to increase knowledge and/or medical intervention. Communities may be involved to some extent in implementing these solutions and may gradually be given more responsibility but the decision-making power rests principally with the external agents with communities principally viewed as the venue and consumers for these programmes (Labonte, 1993).

Community development strategy forms represent a more phenomenological and socially critical socio-environmental orientation to health promotion (Labonte, 1993). They do not view communities as weak or deficient or in need of problem solving expertise by an external agent but rather as strong and competent and in need of capacity building by an external agent to enable them to take control and solve their own problems. In this way these approaches aim to enhance community capacities and build community control rather than to change individual traits which enable community members to identify and define their own concerns and issues and plan their own strategies to mitigate and resolve these (Labonte, 1993). This process requires an analysis of social power relations by the community and external agents and the shifting of these relations towards greater equity (Labonte, 1997).

The two categories can coexist and indeed community-based approaches often arise in the context of a larger community development effort (Labonte, 1996; Hoffman and Dupont, 1992).

**May, Miller and Wallerstein (1993)**

May, Miller and Wallerstein (1993) developed a framework for community mobilisation forms from an organisational communication perspective. This framework made the distinction between categories of: top-down or expert driven forms; and community driven forms (May, Miller and Wallerstein, 1993). Laverack and Labonte (2000) identified the same distinctions in their framework of top down and bottom up categories of health promotion forms. These categories are differentiated by who is driving the mobilisation process - the external agent or the community itself.

In top-down forms external agents are experts who may explore the needs of the community through consultation but develop strategic plans independently of the community itself. The forms aim to deliver services rather than involving local community members in making decisions and taking action (May, Miller and Wallerstein, 1993).

In community-driven forms external agents act as facilitators who build community consensus and promote community decision-making (May, Miller and Wallerstein, 1993). They also act as advocates supporting the community to address the mechanisms that propagate power imbalances.

**Rifkin and Pridmore (2001)**

Rifkin and Pridmore (2001) developed a framework for community participation forms. This framework made a distinction between four categories of forms: information sharing forms; consultation forms; collaboration forms; and empowerment forms. These categories are differentiated by the extent of active involvement of the community in making decisions about issues that affect them.

In information sharing forms external agents give information to lay people. For example, they may disseminate information about an intended programme or they may ask community members to provide information to help plan the programme. As a result, communication in these forms is one-way rather than interactive.

In consultation forms external agents consult the community for their opinions and views. The community typically has no responsibility or involvement in the formulation of the original plan or the decisions that went into it. Furthermore, the external agents are under no obligation to incorporate the views that are gathered from the community. Thus, consultation can be more or less participatory. More participatory consultation may evolve into collaboration or shared control when the community is involved in defining a desired change, or in identifying a problem and its solution. Less participatory consultation may simply aim on gain 'buy in' for a pre-planned activity, prescribed policy or programme.

In collaboration forms the community is actively engaged. Although they may not have initiated the collaboration, they significantly influence the results and the external agents take their perspectives seriously and act on them. For example, they can influence the design of the programme or its implementation.

In empowerment forms the community is engaged through opportunities that allow them to be actively involved in decision-making about the programme. This involves deeper participation than collaboration and results in empowering the community to accept increasing responsibility for developing and implementing the programme and accountability to group members. The external agents become facilitators of a locally-driven process while the community assumes control and ownership of their component of the programme, making decisions accordingly.

### **McLeroy et al (2003)**

McLeroy et al (2003) developed a framework of four categories of community-based health promotion interventions. These categories are differentiated by their implicit constructions of community and include categories of forms: that consider the community to be the setting of the interventions; that view the community to be the target of the interventions; that view the community to be the resource for the interventions; and that view the community to be the agent of the interventions (McLeroy et al, 2003).

Community as setting forms primarily define the community geographically as the location in which the interventions are implemented (McLeroy et al, 2003). The community is often simply the passive recipient of the programmes brought in by external agents although they may sometimes be involved in providing advice to tailor or adapt the programmes to target groups or community characteristics, although the actual tailoring and adaptation is conducted by the external agents rather than the community. The aim of these interventions is to change individual behaviours as a method of reducing the population's risk of disease (McLeroy et al, 2003).

Community as target forms aim to create healthy community environments rather than change individual behaviours. To achieve this indicators of community health status are selected and strategies to improve these are developed and implemented. The interventions hope to achieve improvements in these targeted community health status indicators (McLeroy et al, 2003).

Community as resource forms understand that community ownership and participation are essential for sustained success in population-level health outcomes (McLeroy et al, 2003). These interventions aim to marshal a community's internal resources and assets to strategically focus them on selected priority health related strategies (McLeroy et al, 2003). These strategies



may address health problems identified either by the external agent or by the community itself. Community as resource forms rely to some extent on external actors and resources.

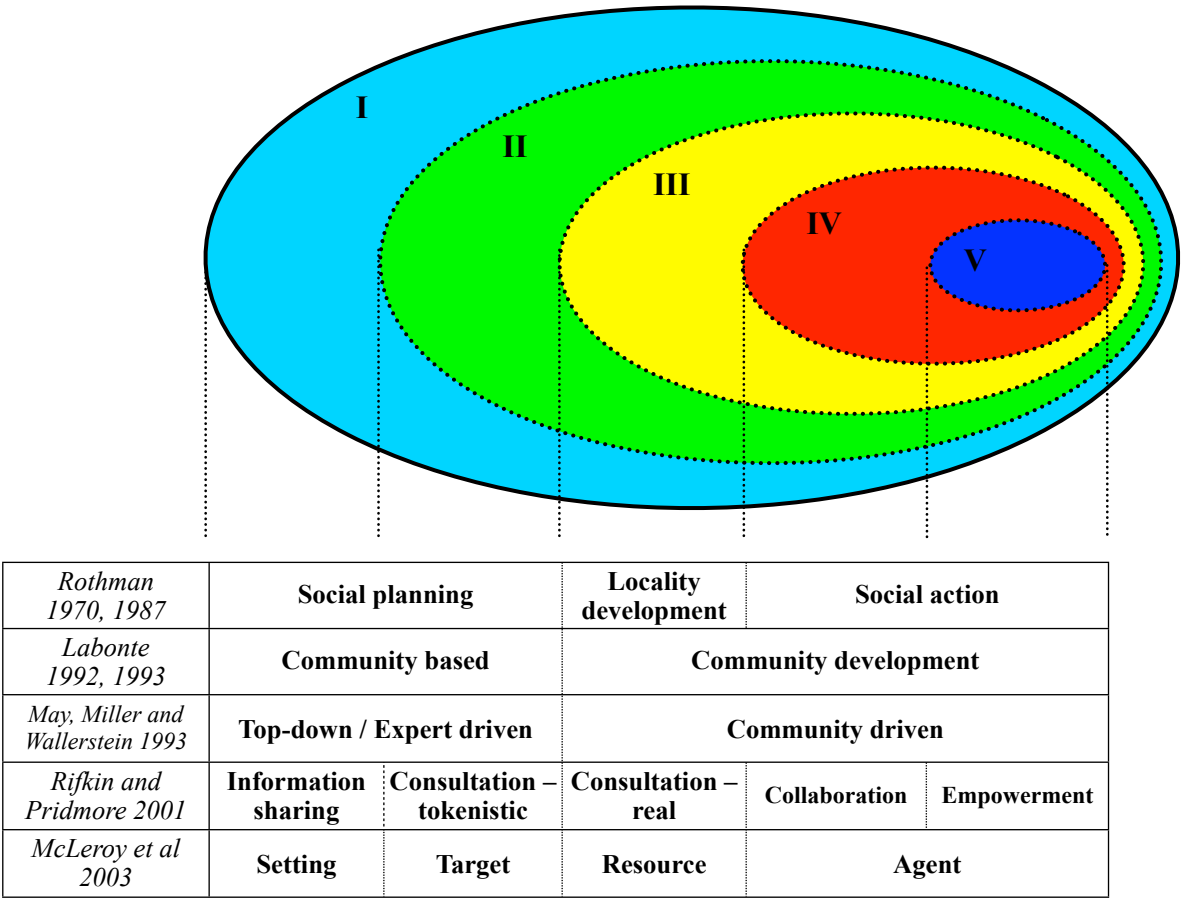
Community as agent forms are the most rare forms. Although similar in some ways to community as resource forms the emphasis of these interventions is to respect and reinforce the natural adaptive, supportive and developmental capacities of communities – the resources for meeting the basic needs of most community members (Steckler et al, 1993). The role of the external agent is to strengthen these ‘units of solution’ so that the community is better able to meet its own needs (McLeroy et al, 2003). As a result, these forms ‘start where people are’ and address issues of common concern to the community, many of which are not directly health issues (Nyswander, 1956).

McLeroy et al (2003) accept that programmes will not fit neatly into the categories but that they will have characteristics drawn from each of the categories.

### **2.2.2 An integrated framework for community mobilisation for health**

Integration of these frameworks facilitates the capture and description of five categories of community mobilisation for health forms: category I forms; category II forms; category III forms; category IV forms; and category V forms (figure 2f - page 62). The five categories represent ideal types along a continuum. Although describing community mobilisation for health forms in this way provides clarity to the concept it must be highlighted that in reality interventions will not fit perfectly into any one of these categories and will have a mixture of characteristics drawn from each of the categories.

Figure 2f: Integrated framework of community mobilisation forms



## **Horizontal description of the five community mobilisation categories**

The following horizontal description of the five categories use a set of practice variables on which the categories can best be differentiated. These variables and the values defined have been synthesised from the different frameworks presented above as well as the health promotion literature. The following variables will be discussed: conceptualisation of health; goal; target group; existing strengths and weaknesses; level and area of participation; role of external agent; role of community; tools and methods; and resources. They are not exhaustive of actual or potential differentiating characteristics but have been selected because they offer the clearest ability to differentiate between categories as well as the most useful information for practitioners about what the forms entail in practice. This horizontal description will consider each of the nine community mobilisation practice variables, in turn, and describe them in terms of each of the five community mobilisation forms.

### *Conceptualisation of health*

As you move along the continuum from category I to V the forms take an increasingly holistic social determinants view of health going from being concerned exclusively with health to being concerned with the issues of power that underpin health (Weil and Gamble, 2002).

Community mobilisation forms in category I define health according to the medical model as the absence of diseases or disorders. Thus, these forms target specific physiological risk factors. Community mobilisation forms in categories II and III define health increasingly according to the behavioural or lifestyle model which views health as the product of making healthy lifestyle choices besides the absence of diseases or disorders. Thus, these forms increasingly target behavioural risk factors. Community mobilisation forms in categories IV and V define health increasingly according to the socio-environmental model which views health as the product of social, economic and environmental determinants in addition the absence of diseases and disorders and making healthy lifestyle choices. These forms target psycho-social risk factors and risk conditions.

- I. Medical model of health concerned with physiological risk factors
- II. Behavioural / lifestyle model of health concerned with behavioural risk factors
- III. Behavioural / lifestyle model of health concerned with behavioural risk factors
- IV. Socio-environmental model of health concerned with psycho-social risk factors and risk conditions
- V. Socio-environmental model of health concerned with psycho-social risk factors and risk conditions

### *Goal*

As you move along the continuum from category I to V the forms take on increasingly process oriented goals. Process goals are concerned with a generalized or gross capacity of the community system to function over time; task goals, with the solution of delimited functional

problems of the system (Rothman and Tropman, 1987). The system targeted for change thus develops along this continuum from the individual in a community to the political structure of the community itself (Weil and Gamble, 2002). Community mobilisation forms in category I stress task goals bound up with the eradication of specific health problems affecting individuals in the community. Community mobilisation forms in categories II and III target increasingly process oriented goals related to specific health behaviours or health knowledge levels of groups of people in the community. Community mobilisation forms in categories IV and V target increasingly process oriented goals related to general increases in the capacities of a community as a whole to address health issues. In these forms the political system becomes the target for change of the interventions rather than the individual community members. Forms of community mobilisation in these categories may also pursue smaller-scale task goals as the process enables them to achieve these aims (Rothman and Tropman, 1987).

- I. Task oriented goals related to the eradication of individual health problems
- II. Process oriented goals related to changes in community health behaviours and health knowledge
- III. Process oriented goals related to changes in community health behaviours and health knowledge
- IV. Process oriented goals related to increases in community capacities and changes in the political system. Communities are enabled to also pursue small scale task oriented goals
- V. Process oriented goals related to increases in community capacities and changes in the political system. Communities are enabled to also pursue small scale task oriented goals

### *Target group*

As you move along the continuum from category I to V the forms target change in increasingly specific and marginalized groups who face systematic barriers to good health. This practice variable does not define which community groups are included in the intervention but rather to which groups are the target of the intervention. Community mobilisation forms in categories I and II view the entire community, usually defined geographically, as the 'client system' (Rothman and Tropman, 1987). This includes both genders and: all age; racial; nationality; religious; economic; social and cultural groups (Heath and Dunham, 1963). Category II forms may target less of the total system compared to category I forms. Some community mobilisation forms in category III might target the entire community but increasingly they target functional subparts of the community that are more marginalized (Rothman and Tropman, 1987). Community mobilisation forms in categories IV and V increasingly target specific subparts of the community, which suffer at the hands of the wider community and are in need of focussed support.

- I. Entire community
- II. Entire community

- III. Entire community and some marginalised functional subparts
- IV. Specific marginalised subparts of the community
- V. Specific marginalised subparts of the community

#### *Existing strengths and weaknesses*

As you move along the continuum from category I to V the forms increasingly recognise and attempt to build on the existing capabilities in communities. Community mobilisation forms in categories I and II view the community as weak, suffering from substantive problems and lacking in the necessary capacities to help itself. As a result, the external agent takes all or the majority of the responsibility to address the situation. This is slightly less the case for category III forms. Community mobilisation forms in category III still view the community as fractured and lacking in skills but accept that some capabilities exist. These forms aim to marshal these existing community resources by bringing people together to focus on the problems at hand. Community mobilisation forms in categories IV and V view the community as capable of solving all the problems it faces. The role of the external agent is thus to reinforce and strengthen these existing capacities to enable them to better meet the needs of community members (McLeroy, 2003).

- I. Community lacks capacities
- II. Community lacks capacities
- III. Community lacks some skills but other capacities exist
- IV. Community has required capacities
- V. Community has required capacities

#### *Level of participation*

As you move along the continuum from category I to V the forms increasingly involve community members in decision-making. Community mobilisation forms in categories I only engage in the most basic form of participation by informing the community of what is planned. Community mobilisation forms in category II and III consult with the community about their views and opinions although the community typically has no responsibility or involvement in the formulation of the original plan or the decisions that went into it. In category II forms these views and opinions are only taken into account tokenistically insofar as they ensure buy in by the community. In category III forms these views and opinions are listened to and are taken into account along with other factors when making decisions. Community mobilisation forms in category IV involve external agents and the community collaborating more closely in making joint decisions and in carrying out the results. The partners are equally responsible for the outcomes of the decisions. Community mobilisation forms in category V are driven by the community. Although similar to category IV forms these forms involve deeper participation as the community leads the process of decision-making and is primarily accountable for the outcomes. These forms require 'starting where people are' and addressing issues of common

concern to the community (Nyswander, 1956). The external agents support this locally owned process and power relations between the two parties are constantly negotiated (Labonte 1997).

- I. Community informed of decisions made
- II. Community consulted about decisions tokenistically to gain buy in
- III. Community consulted about decisions and views are taken into account
- IV. Joint decision-making
- V. Community driven decision-making

### *Role of external agents*

As you move along the continuum from category I to V the forms increasingly position the external agent as a builder of community capacity to address its own problems. The role of the external agent changes from that of a 'coach', 'teacher', 'manager' and 'organiser' to that of an 'advocate' and 'facilitator' (Weil and Gamble, 2002). In community mobilisation forms in categories I and II the external agent takes all or the majority of the responsibility to address the situation and solve any problems without the involvement of the community. The process is 'owned' by the external agent who is central to the decision-making process. In category II forms the external agent start to bring some of the community's own capacities to bear on the situation. In category III forms the external agent brings community members together to identify what collective capacities already exist and that can be used to address the situation. The external agent supports the community to marshal these capacities and focus them on the situation. The external agent and community share 'ownership' of this process. In category IV and V forms the external agent works with the community to reinforce and strengthen the capacities the community has and to build new capacities to enable them to better meet their own needs (McLeroy, 2003). The external agent is a more peripheral figure that communities can choose to draw on as a resource when needed and who responds to these needs. The external agent supports this locally 'owned' and led process (Labonte, 1997). In category V forms the extent of capacity building is broader than in category IV forms.

- I. External agent addresses the situation on behalf of the community. The external agent 'owns' the process
- II. External agent addresses the situation on behalf of the community. The external agent 'owns' the process
- III. External agent supports the community to marshal what existing collective resources they have and focus them to address the situation. The external agent and the community share 'ownership' of the process
- IV. External agent reinforces and strengthens the existing collective resources present in the community. The community 'owns' the process
- V. External agent reinforces and strengthens the existing collective resources present in the community. The community 'owns' the process

### *Role of community*

As you move along the continuum from category I to V the forms increasingly view the community as the active source of the solutions and solver of the problems and less as the passive source of the problems and recipient of the external solution. Community mobilisation category I forms view the community as simply the site of the problem to be addressed - the passive setting and consumer of solutions that are imposed from outside the community. The external agent sets the agenda and identifies which problems need to be addressed.

Community mobilisation category II forms select specific community health status indicators on which to have an impact. In this way the community is viewed as the passive target of these interventions, which again, are imposed from outside the community to solve specific problems. Community mobilisation category III forms recognise that the community is able, to a greater or lesser extent, to provide the solutions to some of the problems itself. In these forms the community is increasingly viewed as an active resource from which the solutions to the problems can be gathered and applied. External agents assist in the process of drawing out these resources and the community takes an active role. However, at the same time the external agent will bring some external solutions and impose them on the community. Community mobilisation category IV and V forms view the community as the near exclusive source of the solutions to the problems being faced. In both forms the community is viewed as the active agent of change who uses these resources to take action and solve the problems it is faced with. However, in category IV forms the external agent may impose a few external solutions. Category V forms define the community in an increasingly specific and targeted manner and support the community to take greater and more extensive action to address its problems. As a result, the community defines its own problems and sets its own agenda.

- I. The community is the setting of the interventions: A broad entity that is the site of the problem and thus setting and passive consumer for the solution
- II. The community is the target of the interventions: The target of external solution
- III. The community is the resource for the interventions: The source of solution but external solutions also used
- IV. The community is the agent of the interventions: A specific and targeted entity which is the main source of the solutions to the problems being addressed and thus the agent for change.
- V. The community is the agent of the interventions: A specific and targeted entity which is the only source of the solutions to the problems being addressed and thus the agent for change.

### *Tools and methods*

As you move along the continuum from category I to V the forms move away from employing methods to eradicate and eliminate negative factors in communities and towards methods that

seek to build on the positive factors that exist. Category I forms principally employ methods that aim to eradicate and eliminate negative factors. These include targeted clinical methods such as immunization campaigns. These methods are generally administered in a short and specific timeframe (Labonte, 1997). Furthermore evaluation of these forms generally involves the assessment of specific risk factors and measures quantitative outcomes and targets (Laverack and Labonte, 2000). Category II and III forms seek to change communities by eliminating negative factors as well as building on positive factors that exist. These increasingly include behaviour change methods such as health education. Category IV and V forms principally employ methods that seek to build on positive factors exhibited by communities. These include capacity building methods such as participatory rural appraisal (PRA) tools. These methods are generally employed for a longer timeframe (Labonte, 1997). Furthermore evaluation of these forms generally involves the use of pluralistic methods that document changes of importance to the community itself (Laverack and Labonte, 2000).

- I. Eradication and elimination of negative factors in communities through targeted clinical methods
- II. Eradication and elimination of negative factors in communities through targeted clinical methods and building of positive factors through behaviour change methods
- III. Eradication and elimination of negative factors and building of positive factors through behaviour change methods
- IV. Building on positive factors through capacity building methods
- V. Building on positive factors through capacity building methods

### *Resources*

As you move along the continuum from category I to V the forms increasingly place the responsibility for mobilisation of resources on the communities themselves. These are the resources, whether financial, symbolic, human, knowledge and skills, natural, etc, that are mobilised by the intervention process and brought to bear directly on the health issues being experienced. In community mobilisation category I and II forms these resources are predominantly mobilised by the external agent. In category I forms all the resources are mobilised by the external agent while in category II forms some of these resources are also mobilised by the community itself. In category III forms the external agent and the community equally share the responsibility for mobilizing these resources. In community mobilisation category IV and V forms these resources are predominantly mobilised by the community from within or outside. In category IV forms the external agent may also mobilise some of the resources but in category V forms all the resources are mobilised by the community alone. In both these forms the external agent may support the community and broker access to these resources.



- I. Resources to directly address health issues are all mobilised by the external agent
- II. Resources to directly address health issues are mobilised predominantly by the external agent but some may also be mobilised by the community itself
- III. Resources to directly address health issues are mobilised equally by the external agent and the community itself
- IV. Resources to directly address health issues are mobilised predominantly by the community itself but the external agent may also mobilise some resources
- V. Resources to directly address health issues are all mobilised by the community itself

### **Vertical description of the five community mobilisation categories**

The following vertical description will consider each of the five community mobilisation forms, in turn, and describe them in terms of the nine community mobilisation practice variables.

This description will present the community mobilisation forms as discrete types. However, practitioners agree that community mobilisation practice does not fit within ideal or discrete types but instead can consist of overlapping forms that coexist and have characteristics drawn from various types (Rothman and Tropman, 1987; Labonte, 1997; McLeroy, 2003).

#### *Category I forms of community mobilisation*

To be considered a category I form the community mobilisation approach must, in practice, define health with the medical model, pursue exclusively task oriented goals and view the community as a very broad entity that is the site of the problems and thus setting and passive recipient of the solutions. Furthermore, the external agent must have the responsibility for mobilising all resources to address the health issues being faced and must make all decisions but involve the community by informing them of these.

Pure forms of these approaches would also target the whole community defined as a geographical entity and would use targeted clinical methods to eradicate and eliminate negative factors that exist. They would employ these methods because they view the community as weak, lacking in capacity and suffering from substantive problems. As a result, the external agent would generally address the problems on behalf of the community and thus would have ownership of the approach.

#### *Category II forms of community mobilisation*

To be considered category II forms the community mobilisation approach must, in practice, involve some form of consultation with the community about decisions being made but this is tokenistic and is carried out simply to gain the buy in of the community. As a result, the community is defined as the passive target of an external solution.

Pure forms of these approaches would also define health with both the medical and behavioural/lifestyle model and would be concerned with process oriented goals related to

changes in community health behaviours and health knowledge. They would generally target the whole community defined as a geographical entity and use targeted clinical methods to eradicate and eliminate negative factors that exist as well as behaviour change methods that seek to build on the positive factors that exist. They would employ these methods because they view the community as weak, lacking in real capacity and suffering from substantive problems. As a result, the external agent would generally address the problems on behalf of the community and thus would have ownership of the approach. This includes the external agent being predominantly responsible for mobilising resources to address the health issue being faced although the community does mobilise some resources.

### *Category III forms of community mobilisation*

To be considered a category III form the community mobilisation approach must, in practice, view the community as an active resource for the solutions to problems being faced. The external agent assists in identifying and marshaling these internal capacities and shares ownership of the approach with communities. Thus the community is consulted in a real way about the decisions being made and these views are listened to and acted upon.

Pure forms of these approaches would also define health with both the behavioural/lifestyle and medical model and would be concerned with process oriented goals related to changes in community health behaviours and health knowledge. They would generally target the whole community although also begin to target particular marginalized subparts of the community that are not defined geographically and would use behaviour change methods that seek to build on the positive factors that exist as well as targeted clinical methods to eradicate and eliminate negative factors that exist. These methods are employed as although the community is considered to be fractured and lacking in some capacities others are considered to exist. As a result, the external agent and the community are equally responsible for mobilising resources to address the health issue being faced.

### *Category IV forms of community mobilisation*

To be considered a category IV form the community mobilisation approach must, in practice, involve the community and the external agent making joint decisions through close collaboration and sharing of responsibility.

Pure forms of these approaches would also define health increasingly according to the socio-environmental model in addition the absence of diseases and disorders and the making of healthy lifestyle choices and aim to achieve process oriented goals by targeting the political system for change. In achieving process goals communities would also be freed to pursue smaller-scale task goals. The target of these interventions are specific marginalised subparts of the community which are believed to have the potential to solve all the problems they face. The role of the external agent would thus be to reinforce and strengthen these existing capacities to

enable them to better meet the needs of community members. Since the community is the source of solutions to the problems being faced it owns and leads the process and is the active agent of change that defines its own problems and sets its own agenda. Also, as a result, the community would be responsible for mobilising the majority of resources needed to address these problems although the external agent may also help to mobilise some resources.

#### *Category V forms of community mobilisation*

To be considered a category V form the community mobilisation approach must, in practice, be driven by the community. As a result, it must involve deep participation where the community leads the process of decision-making and is primarily accountable for the outcomes.

Furthermore, the community must be solely responsible for mobilising the resources needed to address the problems it is facing.

Pure forms of these approaches would also usually define health according to the socio-environmental model besides the absence of diseases and disorders and the making of healthy lifestyle choices and would aim to achieve process oriented goals by targeting the political system for change. In achieving process goals communities would also be freed to pursue smaller-scale task goals. The target of these interventions is a very specific and targeted entity consisting of only the most marginalised subparts of the community. The community is believed to have the potential to solve all the problems it faces. The role of the external agent would thus be to reinforce and strengthen a very broad range of these existing capacities to enable them to better meet the needs of community members. Since the community is the source of solutions to the problems being faced it owns and leads the process and is the active agent of change that defines its own problems and sets its own agenda.

### **2.3 Community mobilisation to address the SDH**

The framework developed above reveals that not all community mobilisation interventions seek to address the SDH. Category I, II and III forms seek simply to change people's behaviour or reduce physiological risks. However, category IV and V forms do seek to develop 'health-enabling environments' and thus also address the negative social circumstances that limit people's control over their behaviour and enhance physiological risk factors (Tawil et al, 1995). These forms of community mobilisation interventions conceptualise health according to the socio-environmental model and seek to achieve process oriented goals related to building the social capacities of communities to make choices and take control of health issues by targeting the political system for change. Thus it is these forms that specifically attempt to address the SDH.

A review of the community mobilisation literature was carried out to identify category IV and V form interventions. The review initially involved a search of PubMed. Searches were limited by

year of publication (up to January 2012) in the English language. Key words searched in title and abstract were ‘community mobilisation’ and ‘community mobilization’. In total 29 articles were identified relating to 23 distinct community mobilisation interventions. An additional 34 articles (63 in total) referring to these interventions were then accessed through PubMed and reviewed. Descriptions of the 23 interventions were assessed using a filtering tool developed from the framework presented above (appendix 1). In particular the extent of control of the community over decision-making, a key defining factor, was carefully considered. A total of 11 category IV and V community mobilisation form interventions were subsequently identified (table 2g - page 73 to 78). These include: the Catholic Women’s Organisation (CWO), Nigeria; the Community Coalition Concerned about SARS (CCCSARS), Canada; the Community Mobilisation Intervention (CMI) within the Avahan AIDS Initiative, India; Ekjut Project, India; Entabeni Project, South Africa; MaiMwana Project, Malawi; Mother and Infant Research Activities (MIRA), Dhanusha, Nepal; Mother and Infant Research Activities (MIRA), Makwanpur, Nepal; Perinatal Care Project (PCP), Bangladesh; Society for Nutrition, Education and Action (SNEHA), India; and Sonagachi Project, India.

Table 2g: Community mobilisation interventions identified through PubMed

Intervention	Articles identified through initial PubMed search	Additional articles reviewed	Community mobilisation form
<b>Amhara Latrine Programme, Ethiopia</b>	<ul style="list-style-type: none"> <li>Ngondi et al. Trop Med Int Health. 2010 May;15(5):592-9. Epub 2010 Mar 16.</li> </ul>	<ul style="list-style-type: none"> <li>Ngondi et al. Trans R Soc Trop Med Hyg. 2009 Oct;103(10):1001-10.</li> <li>O'Loughlin et al. Trop Med Int Health. 2006 Sep;11(9):1406-15.</li> </ul>	<b>I</b>
<b>Catholic Women's Organisation (CWO), Nigeria</b>	<ul style="list-style-type: none"> <li>Ilika and Ilika. Afr J Reprod Health. 2005 Aug;9(2):65-75.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<b>V</b>
<b>Communities Mobilising for Change on Alcohol (CMCA), USA</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Wagenaar et al. Journal of Community Psychology. 1999; 27, 315-326.</li> <li>Wagenaar et al. Journal of Studies on Alcohol. 2000a; 61, 85-94.</li> <li>Wagenaar et al. Addiction. 2000b 95, 209-217.</li> </ul>	<b>I</b>
<b>Community Alcohol Trauma Prevention Trial, USA</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Holder et al. JAMA. 2000; 284:2341-2347.</li> </ul>	<b>I</b>

<b>Intervention</b>	<b>Articles identified through initial PubMed search</b>	<b>Additional articles reviewed</b>	<b>Community mobilisation form</b>
<b>Ekjut Project, India</b>	<ul style="list-style-type: none"> <li>• Tripathy et al. Trials. 2011 Jul 25;12:182.</li> <li>• Rath et al. BMC Int Health Hum Rights. 2010 Oct 22;10:25.</li> <li>• Tripathy et al. Lancet. 2010 Apr 3;375(9721):1182-92.</li> </ul>	<ul style="list-style-type: none"> <li>• NA</li> </ul>	<b>IV</b>
<b>Entabeni Project, South Africa</b>	<ul style="list-style-type: none"> <li>• Campbell and Cornish. AIDS Care. 2010;22 Suppl 2:1569-79.</li> </ul>	<ul style="list-style-type: none"> <li>• Campbell et al. Am J Community Psychol. 2007 Jun; 39(3-4):347-63.</li> <li>• Campbell and Cornish. AIDS Behav. 2012;16(4):847-857</li> </ul>	<b>IV</b>
<b>Innovative Socio-Economic Interventions Against Tuberculosis Project (ISIAT), Peru</b>	<ul style="list-style-type: none"> <li>• Rocha et al. Int J Tuberc Lung Dis. 2011 Jun;15 Suppl 2:S50-7.</li> </ul>	<ul style="list-style-type: none"> <li>• NA</li> </ul>	<b>I</b>
<b>'MaiMwana Project, Malawi</b>	<ul style="list-style-type: none"> <li>• Rosato et al. Malawi Med J. 2010 Dec;22(4):112-9.</li> <li>• Rosato et al. Malawi Med J. 2009 Dec;21(4):168-73.</li> <li>• Lewycka et al. Trials. 2010 Sep 17;11:88.</li> <li>• Rosato et al. Lancet. 2006 Sep 30;368(9542):1180-8.</li> </ul>	<ul style="list-style-type: none"> <li>• Rosato et al. Journal of International Health (In press).</li> <li>• Lewycka et al. Lancet (Submitted).</li> </ul>	<b>IV</b>

<b>Intervention</b>	<b>Articles identified through initial PubMed search</b>	<b>Additional articles reviewed</b>	<b>Community mobilisation form</b>
<b>Mother and Infant Research Activities (MIRA), Dhanusha, Nepal</b>	<ul style="list-style-type: none"> <li>Shrestha et al. Trials. 2011 Jun 3;12:136.</li> </ul>	<ul style="list-style-type: none"> <li>Manandhar et al. Kathmandu Univ Med J (KUMJ). 2010 Jan-Mar;8(29):62-72.</li> </ul>	<b>IV</b>
<b>Community Alcohol Trauma Prevention Trial, USA</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Holder et al. JAMA. 2000; 2341-2347.</li> </ul>	<b>I</b>
<b>Community Coalition Concerned about SARS, Canada</b>	<ul style="list-style-type: none"> <li>Dong et al. J Epidemiol Community Health. 2010 Feb; 64(2):182-3.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<b>V</b>
<b>Community Mobilisation for the Prevention of Alcohol Related Injury (COMPARI), Australia</b>	<ul style="list-style-type: none"> <li>Midford et al. Drug Alcohol Rev. 2005 Jan;24(1):3-11.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<b>III</b>
<b>Community Mobilisation Intervention (CMI) within the Avahan AIDS Initiative, India</b>	<ul style="list-style-type: none"> <li>Blankenship et al. Sex Transm Infect. 2010 Feb;86 Suppl 1:169-75.</li> </ul>	<ul style="list-style-type: none"> <li>Lipovsek et al. Sex Transm Infect. 2010 Feb;86 Suppl 1:125-32.</li> <li>Blankenship et al. AIDS 2008; 22(Suppl 5): S109-16</li> </ul>	<b>IV</b>
<b>Community Safety Action Projects, Australia</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Hauritz et al. 1998 Reducing Violence in Licensed Venues: Community Safety Action Projects. Australian Institute of Criminology, Canberra, Australia.</li> </ul>	<b>I</b>

<b>Intervention</b>	<b>Articles identified through initial PubMed search</b>	<b>Additional articles reviewed</b>	<b>Community mobilisation form</b>
<b>Community Trials Project, USA</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Treno et al. Addiction. 2007; 92 (Suppl. 2), S173–187.</li> </ul>	<b>I</b>
<b>Project Accept, Tanzania, Zimbabwe and Thailand</b>	<ul style="list-style-type: none"> <li>Sweat et al. Lancet Infect Dis. 2011 Jul;11(7):525-32.</li> </ul>	<ul style="list-style-type: none"> <li>Piwowar-Manning et al. BMC Infect Dis. 2011 Sep 24;11:251.</li> <li>Khumalo-Sakutukwa et al. J Acquir Immune Defic Syndr. 2008 Dec 1;49(4):422-31.</li> <li>Genberg et al. J Acquir Immune Defic Syndr. 2008 Nov 1;49(3):309-19.</li> </ul>	<b>I</b>
<b>Safe Water System, Zambia, Madagascar and Kenya</b>	<ul style="list-style-type: none"> <li>Quick. Int J Environ Health Res. 2003 Jun;13 Suppl 1:S115-21.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<b>III</b>
<b>Skilled Care Initiative (SCI), Burkina Faso</b>	<ul style="list-style-type: none"> <li>Hounton et al. Glob Health Action. 2009 May 7;2.</li> </ul>	<ul style="list-style-type: none"> <li>Newlands et al. Trop Med Int Health. 2008 Jul;13 Suppl 1:61-7.</li> <li>Houton et al. Trop Med Int Health. 2008 Jul;13 Suppl 1:53-60.</li> <li>Houton et al. Trop Med Int Health. 2008 Jul;13 Suppl 1:44-52.</li> </ul>	<b>III</b>
<b>Society for Nutrition, Education and Health Action (SNEHA), India</b>	<ul style="list-style-type: none"> <li>More et al. Trials. 2008 Feb 10;9:7.</li> </ul>	<ul style="list-style-type: none"> <li>Fernandez and Osrin. PLoS Med. 2006 Sep;3(9):e339.</li> </ul>	<b>IV</b>



<b>Intervention</b>	<b>Articles identified through initial PubMed search</b>	<b>Additional articles reviewed</b>	<b>Community mobilisation form</b>
<b>Sonagachi Project, India</b>	<ul style="list-style-type: none"> <li>• Campbell and Cornish. AIDS Care. 2010;22 Suppl 2:1569-79.</li> <li>• Evans and Lambert. Soc Sci Med. 2008 Jan;66(2):467-78</li> </ul>	<ul style="list-style-type: none"> <li>• Campbell and Cornish. AIDS Behav. 2012;16(4):847-857.</li> <li>• Swendeman et al. Soc Sci Med. 2009 Oct;69(8):1157-66.</li> <li>• Ghose et al al. Soc Sci Med. 2008 Jul;67(2):311-20.</li> <li>• Cornish and Ghosh. Soc Sci Med. 2007 Jan;64(2):496-507.</li> <li>• Gangopadhyay et al. Sex Transm Dis. 2005 Nov;32(11):680-4.</li> <li>• Jana et al. AIDS Educ Prev. 2004 Oct;16(5):405-14.</li> <li>• Basu et al. J Acquir Immune Defic Syndr. 2004 Jul 1;36(3):845-52.</li> </ul>	<b>IV</b>
<b>STAD Project, Sweden</b>	<ul style="list-style-type: none"> <li>• Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>• Wallin et al. Addiction. 2002; 97, 901-907.</li> <li>• Wallin et al. Journal of Studies on Alcohol. 2005; 66, 806-814.</li> <li>• Wallin et al. Journal of Studies on Alcohol. 2003; 64, 270-277.</li> </ul>	<b>I</b>

<b>Intervention</b>	<b>Articles identified through initial PubMed search</b>	<b>Additional articles reviewed</b>	<b>Community mobilisation form</b>
<b>Surfers Paradise Safety Action Project, Australia</b>	<ul style="list-style-type: none"> <li>Jones et al. Health Place. 2011 Mar;17(2):508-18. Epub 2010 Dec 19.</li> </ul>	<ul style="list-style-type: none"> <li>Hamel et al. 1997 Preventing alcohol-related crime through community action: the Surfers Paradise safety action project, Policing for Prevention: Reducing Crime, Public Intoxication and Injury. Criminal Justice Press, Monsey, NY.</li> </ul>	<b>I</b>
<b>The Lotus Club, Cambodia</b>	<ul style="list-style-type: none"> <li>Busza and Schunter. Reprod Health Matters. 2001 May;9(17):72-81.</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>	<b>III</b>

The 11 identified category IV and V community mobilisation form interventions were compared using the single descriptive Aims, Setting, Target group, Objectives and Resources (ASTOR) format (Hickson, 1999). This framework for the description of interventions defines: their purpose (Aims), the context in which they take place (Setting), the people whom they chiefly seek to influence (Target group), the specific events that take place during their lives (Objectives), and what needs to be put in to them so that they achieve their intended outcomes (Resources) (table 2h - page 82 to 92). At the same time, the interventions were compared using the nine community mobilisation practice variables identified above (figure 2i - page 93).

### **2.3.1 Aims**

The 11 interventions broadly had two types of aims: those concerned specifically with improving health and reducing mortality; and those concerned with building the capacities of communities to take control and thus achieve reductions in disease or mortality. This translates into widely different conceptualisations of health. They ranged from conceptualising health as the absence of disease and the product of healthy lifestyle choices (level II) to the product of multiple interrelated social, economic and environmental factors that determine health status (level V). For example, CCCSARS aimed to prevent and manage the SARS pandemic amongst Chinese Torontonians, while the CMI aimed to organise female sex workers and build their power to address the structural factors that produce HIV risk. This reveals that although some interventions target the physiological and behaviour risk factors that exist in communities others are targeting the psycho-social risk factors and risk conditions.

The interventions also had widely different goals. They ranged from seeking to achieve task-oriented goals related to the eradication of specific health problems (level II) to achieving process-oriented goals related to increasing the social capacities of communities to make choices and take control of health related issues (level V). For example, CCCSARS sought specifically to eradicate SARS, while the CWO advocated with people in positions of power to ratify and support changes in dehumanising widowhood rites.

### **2.3.2 Setting**

The 11 interventions were implemented in a wide range of different settings in Africa, Asia and Northern America. However, they did not differ greatly in the extent to which they considered communities to have existing strengths or weaknesses. They ranged from considering that communities lacked some skills (level III) to considering that they have quite adequate capacity to solve their own health problems (level IV). For example, Entabeni Project described the community as lacking AIDS competence before the intervention was implemented, while MaiMwana Project considered the community, because of its experiences, to be the primary locus of the solutions to MCH problems.

### **2.3.3 Target population**

The 11 interventions targeted widely different groups defined by their gender, occupation, ethnicity or pregnancy status. They ranged from targeting the whole community and some subparts within it (level II) to targeting a much narrower community defined by the fact that they suffer at the hands of the wider community (level V). For example, MIRA Dhanusha targets all community members, while Sonagachi Project specifically targets impoverished and excluded female sex workers who's rights and interests and not considered by more powerful groups.

### **2.3.4 Objectives**

The 11 interventions employed a range of methods. Some operated through individuals while others operated through groups and coalitions. Some employed a mixture of service delivery, health education and community capacity building methods while others employed predominantly community capacity building methods. Five of the interventions (Ekjut, MaiMwana, MIRA Dhanusha, MIRA Makwanpur, PCP and SNEHA) were implemented using evolutions of a similar women's group community action cycle methodology.

In all the interventions the communities were involved extensively in decision-making either doing so in collaboration with an external agent (level IV) or alone (level V). This level of involvement is what defines these interventions as type IV or type V community mobilisation forms. For example, in MIRA Makwanpur, the external agents and the community collaborated to make decisions and were jointly accountable, while in CWO the members drove the intervention and were solely responsible for all the decisions made.

As might be expected these similarities in participation are also reflected in the roles of the external agent and roles of the community in the interventions. These ranged from interventions where the external agent and the community jointly 'owned' the intervention (level IV) to those where the intervention was 'owned' by the community and the external agent was called on only when certain expertise was needed (level V). For example, in PCP the community was active and involved in leading the intervention process in close collaboration with the external agent, while in CWO the community was solely responsible for running the intervention but drew on external stakeholders to support the process where necessary.

There was marginally more divergence between the interventions in the tools and methods employed. These ranged from interventions that used tools to develop the knowledge and awareness of communities to help them address their problems (level III) to those that used tools to build the social capacities of communities to make decisions and take control of their health (level V). For example, CCCSARS predominantly used health education to raise awareness and change attitudes and behaviour, while Ekjut Project predominantly used

participatory tools to build the capacities of communities to address the social determinants of MCH.

#### **2.3.5 Resources**

The 11 interventions use different approaches to mobilise resources that are brought to bear on the health issue of importance. They ranged from external agents and the community equally mobilising resources (level III) to all the resources being mobilised by the community alone (level V). For example, in Entabeni Project the resources to establish the project were mobilised by the external agent and the community together, while CCCSARS mobilised all the necessary resources itself from within and outside the community.

*Table 2h: Key characteristics of 11 community mobilisation category IV and V form interventions*

<b>Intervention</b>	<b>Aim</b>	<b>Setting</b>	<b>Target population</b>	<b>Methods</b>
<b>Catholic Women's Organisation (CWO), Nigeria</b>	To eliminate dehumanising widowhood practices.	Ozubulu Parish, Nigeria.	Primarily women.	Meetings of central executives of CWO to identify principal dehumanising widowhood rites, factors that support these rites, identification of resolutions regarding these rites, advocating for these resolutions amongst religious leaders and town and union traditional leaders, advocacy with other women's groups and handling opposition from men.

Intervention	Aim	Setting	Target population	Methods
<p><b>Community Coalition Concerned about SARS (CCCSARS), Canada</b></p>	<p>To combat the SARS outbreak amongst Chinese Torontonians.</p>	<p>Toronto, Canada.</p>	<p>Primarily the Chinese population living in Toronto.</p>	<p>Developing a coalition of Chinese-Canadian organisations and through this: disseminating SARS related information in Chinese, fighting discrimination through advocacy, organising events to support front-line health workers and raise funds for research, organising promotional activities to support local businesses and operating community-based telephone support lines.</p>

Intervention	Aim	Setting	Target population	Methods
<p><b>Community Mobilisation Intervention (CMI) within the Avahan AIDS Initiative, India</b></p>	<p>To organise female sex workers (FSWs) to build collective power and direct this towards addressing structural factors that produce HIV risk among FSWs.</p>	<p>Rajahmundry, Andhra Pradesh, India</p>	<p>Primarily female sex workers.</p>	<p>FSWs as social change agents so that they engage in both health education and community organising. Community organising activities include: leading attending public rallies, meeting with the media, public officials and local community groups to raise awareness of the issues faced by FSWs, advising and participating in the operations of intervention-run STI clinics, responding to incidents of police brutality against FSWs and organising community based organisations comprised of and led by FSWs.</p>



Intervention	Aim	Setting	Target population	Methods
<p><b>Ekjut Project, India</b></p>	<p>To build the capacities of communities to take control of the MCH issues that affect them.</p>	<p>West Singhbhum, Saraikela and Kharsawan Districts, India.</p>	<p>Primarily women of reproductive age (15 - 49) and their children.</p>	<p>Community groups are formed and facilitated through a 20 meeting community-action cycle by trained, paid local female facilitator. The cycle consists of four phases: identifying and prioritising difficulties together, planning strategies together, putting strategies into practice together, and assessing effects together. Discussion is supported and stimulated by PRA tools and picture cards.</p>

<b>Intervention</b>	<b>Aim</b>	<b>Setting</b>	<b>Target population</b>	<b>Methods</b>
<b>Entabeni Project, South Africa</b>	To build the capacity of poor rural women to deliver effective home nursing to people dying of AIDS.	Entabeni, South Africa.	Primarily people dying of AIDS.	Volunteers trained in home nursing, peer education and counselling skills providing home-based care support to people dying of AIDS. In parallel, building the recognition and support of community members and building bridges between volunteers and external supporters.

Intervention		Aim	Setting	Target population	Methods
<b>MaiMwana Project, Malawi<sup>1</sup></b>		<p>To build the capacities of communities to take control of the MCH issues that affect them.</p>	<p>Mchinji District, Malawi.</p>	<p>Primarily women of reproductive age (15 - 49) and their children.</p>	<p>Community groups are formed and facilitated through a 20 meeting community-action cycle by trained, paid local female facilitator. The cycle consists of four phases: identifying and prioritising problems together, planning strategies together, implementing strategies together, and evaluating together. Discussion is supported and stimulated by PRA tools and picture cards.</p>
<sup>1</sup> MaiMwana Project women's groups are described in detail in chapter 4.					

Intervention	Aim	Setting	Target population	Methods
<b>Mother and Infant Research Activities (MIRA), Dhanusha, Nepal</b>	To reduce perinatal and neonatal mortality and improve maternal and infant nutrition.	Dhanusha District, Nepal.	Primarily married women of reproductive age (15 - 49) and their children.	Community groups are formed and facilitated through a 38 community-action cycle by female community-health volunteer. The intervention consists of two four phase cycles: pre-implementation, community meetings to plan and enlist support, implementation and evaluation. The second cycle has additional nutritional content. Discussion is supported by PRA tools. In parallel with the cycle, participatory health education was carried out using picture cards.

Intervention	Aim	Setting	Target population	Methods
<b>Mother and Infant Research Activities (MIRA), Makwanpur, Nepal</b>	To reduce neonatal mortality.	Makwanpur District, Nepal.	Primarily married women of reproductive age (15 - 49) and their children.	Community groups are formed and facilitated through a 19 meeting community-action cycle by trained, paid local female facilitator. The cycle consists of four phases: pre-implementation, community meetings to plan and enlist support, implementation and evaluation. Discussion is supported by PRA tools. In parallel with the cycle, participatory health education was carried out using picture cards.

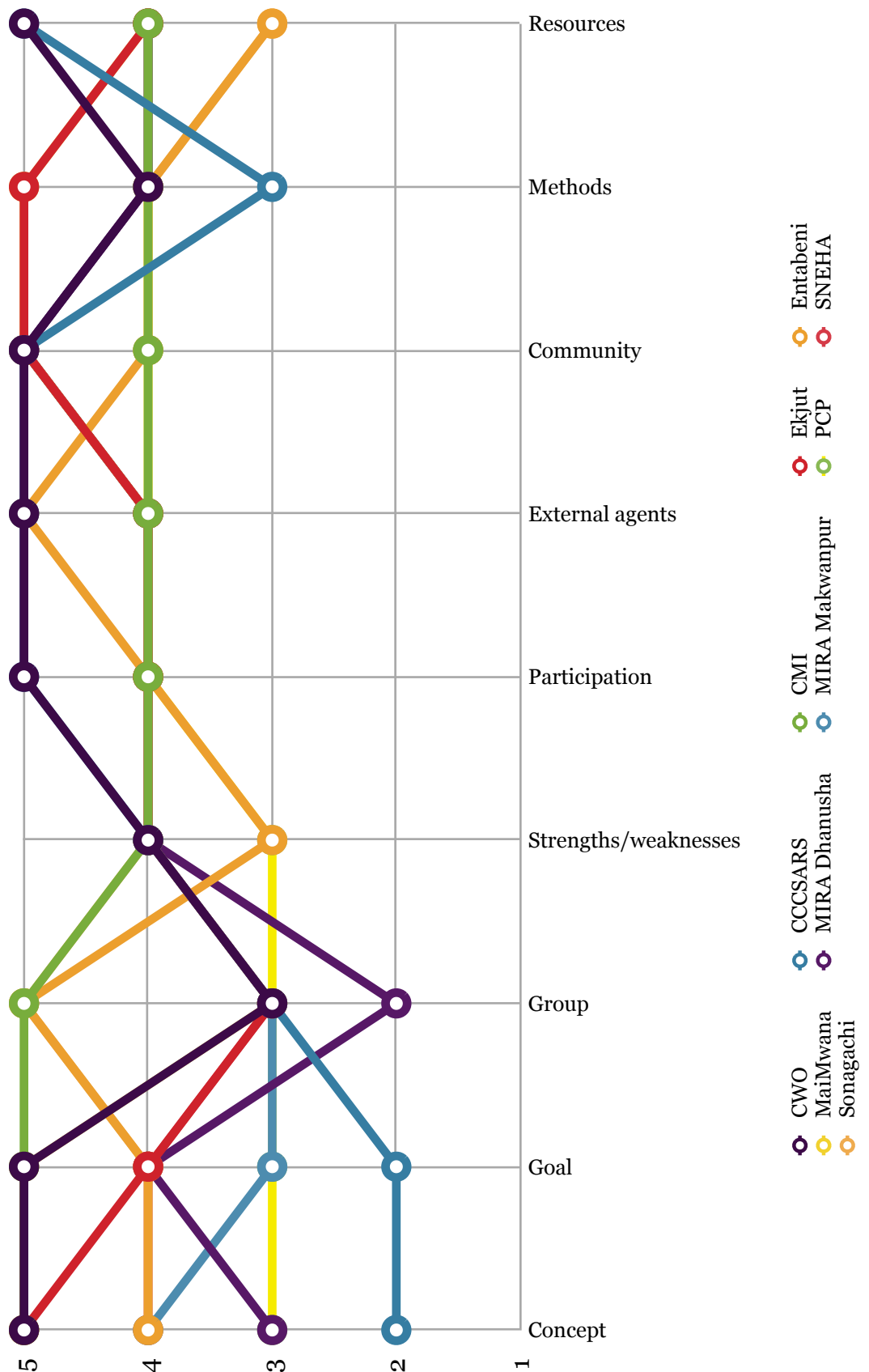
Intervention	Aim	Setting	Target population	Methods
<p><b>Perinatal Care Project (PCP), Bangladesh</b></p>	<p>To reduce maternal and neonatal mortality and morbidity.</p>	<p>Bogra, Fardipur and Moulavibazar Districts, Bangladesh.</p>	<p>Primarily married women of reproductive age (15 - 49) and their children.</p>	<p>Community groups are formed and facilitated through a 20 meeting community-action cycle by trained, paid local female facilitator. The cycle consists of four phases: identifying and prioritising difficulties together, planning strategies together, putting strategies into practice together, and assessing effects together. Discussion is supported and stimulated by PRA tools and picture cards.</p>

Intervention	Aim	Setting	Target population	Methods
<p><b>Society for Nutrition, Education and Health Action (SNEHA), India</b></p>	<p>To improve the survival and health of newborn infants and mothers by improving care practices and care seeking.</p>	<p>Slum communities in Mumbai, India.</p>	<p>Primarily women of reproductive age (15 - 49) and their children.</p>	<p>Community groups are formed and facilitated through a 38 meeting community-action cycle by a local female facilitator. The cycle consists of seven phases: discovery, perception, energy, dreaming, designing, delivery and evaluation. Discussion is supported and stimulated by PRA and appreciative enquiry tools and picture cards.</p>

Intervention	Aim	Setting	Target population	Methods
<b>Sonagachi Project, India</b>	To build the capacity of impoverished and excluded sex workers to take control over their sexual health.	Kolkata, India.	Primarily sex workers.	Peer education (health education, dissemination of information about HIV transmission and prevention, promotion of condom use and encouraging sex workers to attend sexual health clinics) delivered by trained sex-workers and provision of sexual health clinics. In parallel, establishment of a sex worker organisation to unite sex workers to fight for their rights and represent their interests in negotiations with more powerful groups and expand provision from clinic-based health interventions to social interventions.



Figure 2i: Comparison of the 11 type IV community mobilisation form interventions using the nine community mobilisation practice variables



## **Chapter 3: Community empowerment**

### **3.1 Community empowerment**

Imparting knowledge and skills alone has little potential to change people's behaviour where negative social circumstances - the SDH - limit people's control over their behaviour (Campbell and Cornish, 2010a). To enable health-enhancing attitude and behaviour change, approaches need to also develop 'health-enabling environments' to address the SDH (Tawil et al, 1995). However, 'power is never conceded without demand' and 'dominant groups seldom voluntarily relinquish power without vociferous demands from the excluded' (Seedat, Duncan and Lazarus, 2001; Campbell and Cornish, 2010a). As a result, a key strategy for building health-enabling social environments is that of building the capacity or voice of poor people to challenge unequal social relations placing their health at risk (Campbell and Cornish, 2010a). In other words it is necessary to empower communities to take control of their health.

Chapter 2 revealed that it is category IV and V forms of community mobilisation interventions that seek to empower communities to take social and political action. These forms mobilise communities to develop higher levels of social and organisational interaction and in so doing, build and strengthen the capacities of communities to make choices and act collectively to address the issues facing them, target the political system for change, enable and motivate communities to take an active role in meeting their own needs, encourage communities to take the lead in decision-making and take ownership over the intervention process and ultimately the health issues facing them.

These forms also go beyond the customary definition of a community as simply a geographical place where people live, to defining them as "groups of people perceiving common needs and problems, that acquire a sense of identity focussed around these problems and that a common set of objectives grow out of these identified issues" (Ward, 1987). As a result, communities consist of heterogeneous individuals with changing and dynamic social relations who can organise themselves into groups to take action towards achieving shared goals - who can become empowered (Laverack, 2005).

#### **3.1.1 The concept of empowerment**

The concept of empowerment can be traced back to the social action ideologies, adult education philosophies, feminist, civil rights and self-help movements of the 1960s and 1970s (Eklund, 1999). The work of Alinsky (1971) and Freire (1970, 1973 and 1996) are particularly seminal in the development of the concept. Alinsky (1971) posited that low-income communities were powerless and disenfranchised compared to the 'haves' and society as a whole. To bring power back in balance, low-income communities needed to organise themselves to come together around a shared interest or concern. In this way the community increased its problem solving

capacities and its abilities to collectively identify and freeze targets, garner resources, and mobilise an action campaign (Eklund, 1999).

Freire (1970, 1973 and 1996) made a similar distinction between the 'oppressed' and 'oppressors' in society. He set forth a view of people as incomplete beings whose vocation was to become fully human by reflecting critically on objective reality and taking action based on that reflection to transform their worlds (Freire, 1970). According to Freire, the process developing critical consciousness involved groups; first, reflecting on aspects of their reality; second, looking behind these immediate problems to surface their root causes; third, examining the implications and consequences of these issues; and finally developing a plan of action to deal with the problems identified (Freire 1970, 1973 and 1996).

This interactive process involved two aspects. First, a constructive dialogue between individuals in similar situations and the opportunity to connect personal experience with larger social processes. Second, the combination of action and reflection - a praxis - which promoted the development of skills for effective action. The process develops groups with feelings of identification amongst members, a sense of shared fate, a belief that effective self and collective actions are possible and in their abilities to develop effective strategies to take these actions (Eklund, 1999). Oppressed groups, through this process of critical thinking, begin to take actions to transform their social conditions and gain control over their lives (Wallerstein, 1992). It is a revolutionary rather than reformist process as it concentrates on developing the skills of groups to change the structure of society rather than simply integrating them more successfully into the existing structure (Minkler and Cox, 1980).

The empowerment concepts of Alinsky and Freire share common processes of personal development, participation, consciousness-raising, and social action (Rissel, 1994). As a result, empowerment ranges from a focus on individual control to an emphasis on political influence over the distribution of social and economic resources (Solomon, 1976; Maier and Seligman, 1976; Bandura, 1982; Bookman and Morgan, 1988; Zimmerman and Rappaport, 1988; Zimmerman, 1990a,b). It involves people participating in the democratic life of the community and thus gaining control, mastery and purposefulness to take social and political action to improve their life situations in the context of their social, economic and political environment (Gutierrez, 1988; Kieffer, 1981; Wallerstein 1992). This has led theorists to identify two distinct components to the concept of empowerment: a psychological or subjective component and a political or objective component (Rappaport, 1985; Swift and Levin, 1987).

The psychological component refers to the subjective experience of one's competence and efficacy as well as one's involvement in activities for exerting control in the social and political environment (Eklund, 1999). The development of this component is bound up in processes of personal development, participation and consciousness raising. Powerlessness also has a subjective component. People may learn helplessness (Maier and Seligman, 1976); have an

external locus of control (Rotter, 1971); or feel alienated from the world in which they live (Seeman, 1959).

The political component refers to the objective reality of structural conditions that dictate the allocation of resources (Swift and Levin, 1987). In society different groups possess different levels of power and control over resources (Bachrach and Baratz 1970). People who lack economic and political power, and live in conditions of poverty and resource privation internalize these as feelings powerlessness (Gaventa, 1980; Albee, 1981). As a result, the political component of empowerment is bound up in the process of social action through which individuals, organisations, and communities to come together to challenge the people and structures which disempower them and demand fairer social structures at all levels (Gerschick et al, 1990).

### **3.1.2 The three levels of empowerment**

Empowerment practice has predominantly focused on the psychological component. This conservative approach often leads to individuals being blamed for not having the skills or motivation to rise up out of powerlessness (Ryan, 1976). However, since the concept is accepted to include both psychological and political components it is not adequate to consider individuals as separate from their social context. Of particular importance amongst the contextual spheres are the social networks, organisations and communities in which individuals are embedded and in which they act and interact and where people and structures can contribute to disempowering them (Gottlieb and McLeroy, 1994). As a result, empowerment can be conceptualised at three levels (Schulz and Israel, 1991) (figure 3a - page 97):

1. The individual level at which empowerment is concerned with personal power and the self-efficacy and basic skills of individuals.
2. The organisational level at which empowerment is concerned with social power and the ability of individuals and organisations to influence others.
3. The community level at which empowerment is concerned with political power and the ability of individuals, organisations and communities to influence the allocation of social and economic resources.

Figure 3a: Empowerment components, levels, dimensions and elements

Empowerment			
Psychological	Political		Components
Individual	Organisational	Community	Levels
Personality Cognitive Motivational Contextual	Empowered Empowering	Individual Organisational Community	Dimensions
<i>Includes:</i> Self efficacy Self confidence Internal locus of control Chance control Belief in powerful others Control ideology Political efficacy Self and political efficacy expectations Desire to control environment Sense of civic duty to participate Cultural awareness Consciousness of community problems Perceptions of ability to have ecological and cultural influence Involvement in collective action	<i>Includes:</i> Sense of community Identification of community members as members of the community Ability of community to organise itself to manage community problems Participation of community members in decision-making	<i>Includes:</i> Equal distribution of resources Improved neighbourhood Improved quality of life and social justice Political action Redistribution of resources and decision-making	Elements

## **Individual level**

At this level empowerment is synonymous with psychological empowerment and refers to an individual's ability to make decisions, have control and act effectively in life (Israel et al, 1994; Gerschick et al, 1990). It consists of individuals establishing a critical or analytical understanding of their social and political context, cultivating individual and collective resources and skills for action and actively participating in groups (Keiffer, 1984).

Individual empowerment includes personality, cognitive, motivational, and contextual dimensions. The personality dimension includes: self-efficacy and self confidence, internal locus of control, sense that things are not a consequence of chance but the result of an individual's own actions and within their own control, the feeling of being stronger within a group or a community than alone and the sense that people in general and oneself in particular can influence social and political systems (Eklund, 1999). The cognitive dimension includes: self-efficacy, political efficacy and self- and political efficacy expectations (Zimmerman and Rappaport, 1988). The motivational dimension includes: an individual's desire to control the environment and the sense of civic obligation to participate in political processes as a responsibility to others. The contextual dimension includes: an individual's cultural awareness and consciousness of community problems together with a perception of their ability to have ecological and cultural influence and their actual involvement in collective action to control the social and political environment (Rappaport 1985; Zimmerman 1990b; Wallerstein 1992, Israel et al. 1994; Freire 1970; Hart and Bond 1995).

Thus, in summary, empowerment at the individual level combines (Zimmerman 1990b):

1. Personal efficacy and competence,
2. A sense of mastery and control, and
3. A process of participation in influencing institutions and decisions.

Individual empowerment is linked with the organisational and community levels through the development of personal control and competence to act, social support, and the development of interpersonal, social and political skills and resources (Kieffer 1984; Schulz et al, 1995).

## **Organisational level**

Organisational empowerment has two dimensions: empowered organisations and empowering organisations (Crowfoot, 1981; Gerschick et al., 1990). Empowered organisations are democratically organised so that members share power and information, have control over processes and structures and are involved in their design and implementation to achieve their goals. Empowering organisations empower of their members by providing them with opportunities to grow and make decisions through their organisational processes (Gerschick et al, 1990).

This conceptualisation of organisations provides the link between the organisation level and individual and community levels of empowerment (Schultz et al, 1995). On one hand empowerment at the organisational level incorporates processes that enable individuals to increase their control within the organisation while on the other hand it incorporates processes that enable the organisation to influence policies, decisions and the distribution of social and economic resources in the larger community (Zimmerman, 1995; Gerschick et al, 1990; Schulz et al, 1995). Thus, empowered organisations link empowered individuals and effective political action (Laverack, 2004).

### **Community level**

Communities include some individuals and organisations who are in positions of powerlessness compared to others. The aim of community empowerment is to support these individuals and organisations to take social action to achieve an increase in decision-making and control, equitable distribution of resources, and improved quality of life (Wallerstein, 1992; 2002). To achieve this individuals and organisations are supported to apply their skills and resources in collective efforts (Gerschick et al, 1990). This process of participation and control enables the community to meet the needs of its individuals and organisations by shaping the conditions of the community to allow the redistribution of resources and decision making favourable to the community, organisations or individuals in question (Schulz et al, 1994; Rissel, 1994). As such, community empowerment is simultaneously a collective and individual phenomenon which includes individual, organisational and community dimensions (Israel et al, 1994; Rissel, 1994). The individual dimension of community empowerment provides individuals with opportunities for personal change:

1. A raised level of psychological empowerment among members of the community (Wallerstein, 1992),
2. An ability of community members to identify problems in the community and their solutions (Braithwaite and Lythcott, 1989),
3. An ability of community members to make a critical analysis of the world (Wallerstein, 1992),
4. An increased participation of community members in community activities (Chavis and Wandersman, 1990; Florin and Wandersman, 1990),

The organisational dimension of community empowerment provides individuals and organisations with opportunities for active participation:

1. A stronger sense of community among the members of community (Chavis and Wandersman, 1990),
2. An identification of community members as members of the community (Wallerstein, 1992),
3. An ability of community members to organise itself to manage a community problems (Rissel, 1994; Minkler, 1994),

4. The initiative and participation of community members in decision making as well as in planning or other committees (Rissel, 1994; Minkler, 1994).

The community dimension of community empowerment provides individuals, organisations and communities with opportunities to shape access to social, political and economic resources:

1. An achievement of equity of resources (Katz, 1984; Rappaport et al, 1985; Rissel 1994),
2. An improved neighbourhood as a consequence of the activities of community (Chavis and Wandersman, 1990),
3. An improved quality of community life and social justice (Wallerstein 1992),
4. Political action in health (Rissel, 1994; Minkler, 1994),
5. A redistribution of resources and decision making (Rissel, 1994).

The three dimensions have independent properties but are not mutually exclusive (Israel et al, 1994). For example, one must first be empowered at the individual level before it is possible to continue to higher levels (Zimmerman and Rappaport, 1988). The reverse is also true as action at the organisational or community level enhances the collective problem-solving capabilities and influences the control over resources of individuals (Israel et al, 1994).

Many socio-environmental risk factors cannot be controlled or changed by one individual (Israel et al, 1994). These troubles facing individuals are often embedded in the context of families and communities (Gerschick et al, 1990). Thus, programmes aimed at individual empowerment, which do not promote collective efforts and do not also consider the organisational and community context in which individuals are embedded, are less likely to increase the influence and control of individuals and thus improve their health and quality of life (Israel et al, 1994). Instead, programmes must seek to increase community empowerment as this has the potential to increase the degree of psychological empowerment among community members, their active participation in decision-making through groups and organisations and their actual control over resources and decision-making.

### **3.1.3 The community empowerment continuum**

Community empowerment has been defined as both a process through which people, organisations and communities gain control over their lives and an outcome that occurs when power is used to solve problems and get a fair share of resources and involvement in decision-making (Rappaport et al, 1984; Wallerstein, 1992; Gutierrez, 1994; Israel et al, 1994)

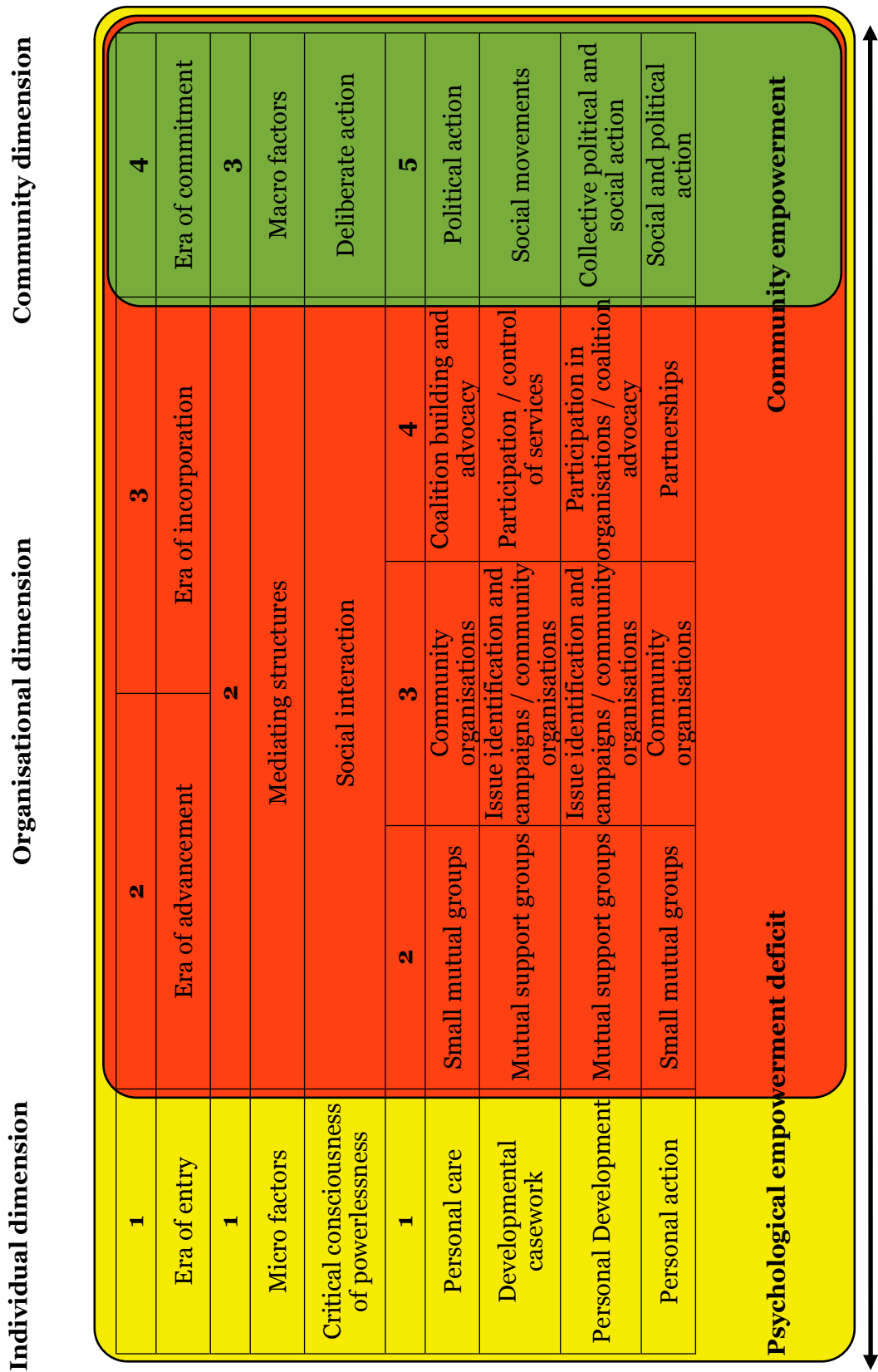
As an outcome it can be measured in terms of psychological, organisational and community aspects (Wallerstein, 1992). However, conceptualising community empowerment as an outcome implies 'a fixed state of achievement' (Wallerstein, 1992). This stands at odds with the general understanding of empowerment as fluid, dynamic and never complete (Wallerstein,



1992; Labonte, 1992). Furthermore, power is never absolute as it only ever exists in particular contexts and in relation to particular topics (Rappaport, 1985; Laverack, 1999).

For these reasons community empowerment is most commonly viewed as a process. More specifically as a social action process promoting the participation of disadvantaged individuals, organisations and communities towards the goal of mastery and control over their lives, political efficacy, improved quality of life and social justice (Rappaport et al, 1984; Werner, 1988; Wallerstein, 1992). Different theorists have developed different schema to represent this process. Common to all of these is a dynamic social-action continuum progressing through the three dimensions of community empowerment described above: from personal development (individual dimension), through participation and consciousness raising (organisational dimension) and to social action (community dimension) (figure 3b - page 102). For simplicity the complex continuum has been depicted here, as in the literature, as linear.

Figure 3b: Models of the community empowerment social action continuum



Kieffer  
(1984)

Torre  
(1986)  
Swift  
and Levin  
(1987)

Labonte  
(1989b)  
Jackson et  
al, 1989  
Rissel  
(1994)  
Laverack  
(1999)

**Kieffer (1984)**

Kieffer (1984) proposed a four stage model of the community empowerment process based on studies of psychological empowerment of participants in grassroots community organisations. The stages include: 'era of entry' where individuals make initial and tentative exploration of authority and power; 'era of advancement' where individuals engage in mentoring and peer support relationships which increase their critical understanding through dialogue and mutual problem solving; 'era of incorporation' where individuals develop their organisational and political skills and begin to confront the sources of their disempowerment; and 'era of commitment' where the social actions in the previous stages are integrated into the reality and structure of everyday life.

**Torre (1986)**

Torre (1986) proposed a three stage model of the community empowerment process including: micro factors such as the intra-personal development of self-esteem and self-efficacy (Bandura, 1982; 1986), mediating structures, such as the group mechanisms through which individuals actively participate, share knowledge and raise their critical consciousness (Friere, 1973), and macro factors such as social and political activities. Torre (1986) stated that all three stages must be present for community empowerment to occur.

**Swift and Levin (1987)**

Swift and Levin (1987) also proposed a three stage model of the community empowerment process. At stage one people develop a critical consciousness of their powerlessness. At stage two they feel strongly about this inequity and build comradeship with like-minded persons through social interaction. At stage three the like-minded groups engage in deliberate action to change the social conditions creating their powerlessness. Swift and Levin (1987) stated that all three stages are needed for community empowerment, with each a prerequisite for the next.

**Jackson et al. (1989), Labonte (1989b), Rissel (1994) and Laverack (1999)**

Considering the work of Kieffer, Torre and Swift and Levin a number of theorists have evolved and refined a five-point dynamic continuum to describe the process of empowerment for use by health promotion practitioners. It is in this form that community empowerment is most consistently viewed in the health promotion literature (Laverack, 1999).

The continuum describes the synergistic interplay between individual empowerment, organisational empowerment, and broader social and political actions (Rosato et al, 2008). It illustrates how community empowerment involves individuals, organisations and communities engaging in different and progressively more organised and broadly based forms of social and political action (Jackson et al, 1989; Labonte, 1989b; Rosato et al, 2008). It is important to highlight that the continuum is a simple linear representation of a dynamic and complex concept (Laverack, 1999). Each point on the continuum can be viewed as an outcome in itself

that, although necessary, is in itself insufficient for community empowerment (Gerschick et al, 1990; Rissel, 1994). Furthermore, each point is a progression on the process to the next point, although each point does not automatically follow on from the previous one (Gerschick et al, 1990; Rissel, 1994).

*Personal care (Labonte, 1989b) / Personal action (Laverack, 1999) / Personal development (Rissel, 1994) / Developmental casework (Jackson et al, 1989)*

The process of community empowerment begins with an assumption that a power deficit or an unattended social problem exists. To address this problem, at this first level, community empowerment involves the personal development of individuals in terms of personal efficacy and a sense of mastery and control (Bandura, 1982). The catalyst for personal development is often a response to an emotional or symbolic experience in life (Keiffer, 1984). Drawing on these capacities individuals become willing and able to link with others in groups and function effectively within them enabling them to better define, analyse and act on issues of concern (Rissel, 1994; Laverack, 1999).

*Small mutual groups (Labonte, 1989b; Laverack, 1999) / Mutual support groups (Rissel, 1994; Jackson et al, 1989)*

At this level individuals become empowered to develop small groups of mutually concerned individuals. These include self-help groups organised around a specific problem, community health groups and community development health projects (Jones and Sidell, 1997). It is through interacting with others in small groups that individuals gain characteristics essential for empowerment: control, skills and capacity, awareness of social and political issues, social support and expanded opportunity networks, social coherence and interpersonal connectedness (Kieffer, 1984; Wallerstein, 1992; Putnam et al, 1993). In other words, through small groups, individuals find a 'voice' and become able to participate in a more formal way to achieve social and political change (Laverack, 1999). They also provide a forum to help normalise individual problems and reduce isolation and self-blame (Labonte, 1992). For these reasons, small groups have been described as the 'locus of change' and 'vehicle for emancipation' (Labonte, 1992). They are the key socio-structural unit in empowerment practice as they provide support for the personal development process of individuals while at the same time embodying the start of collective action.

*Community organisations (Labonte, 1989b; Laverack, 1999) / Issue identification and campaigns/community organisation (Rissel, 1994; Jackson et al, 1989)*

At this level groups become empowered to develop community organisations. These are the means for people with common needs to meet them through social and political action (Alinsky, 1969). Compared to some mutual groups, community organisations are larger, have an established structure, more functional leadership and the ability to organise their members and mobilise resources (Laverack, 1999). Through participation in these organisations people have

the opportunity to collaboratively reflect, question, share experiences and develop solutions. This develops their awareness of their problems, how political structures operate and cause these problems and skills and solutions to address them. As a result, they become organised and mobilised around these issues to develop plans, mobilise resources and undertake actions to deal with the broader political and social issues affecting them (Rissel, 1994).

These organisations focus outwards on the broader environment that underpins the needs of the group members rather than inwards, as small mutual groups do, on the immediate concerns of the group members themselves. It is this outwards focus that makes the transition to social action possible as it provides a starting point for efforts to solve wider community problems (Labonte, 1990; Rifkin, 1990).

*Coalition building and advocacy (Labonte, 1989b) / Partnerships (Laverack, 1999) / Participation in organisations/coalition advocacy (Rissel, 1994) / Participation/control of services (Jackson et al, 1989)*

At this level community organisations become empowered to join to develop coalitions and partnerships. The partner groups share goals of social and political change and an understanding of the benefits of collective action in the pursuit of joint ventures (Laverack, 1999). Through these coalitions and partnerships, community organisations can grow beyond their local concerns and develop their problem solving capacities, strengthen their social networks, better compete for limited resources and ultimately engage in advocacy on broader issues by initiating actions in a deliberate attempt to influence private and public policy choices (Batten, 1967; Labonte, 1992). These actions can relate either to their own organisational concerns or those of other member organisations (Laverack, 1999).

*Political action (Labonte, 1989b) / Social and political action (Laverack, 1999) / Collective political and social action (Rissel, 1994) / Social movements (Jackson et al, 1989)*

At this level coalitions and partnerships become empowered to take social and political action which is necessary as the members live in unsupportive and disabling environments where they are deprived of access to political influence and resources. As Laverack (1999) stated: “If concerned individuals remained at the small mutual group level, the conditions leading to their poverty would not be resolved. If people only engaged in mainstream forms of lobbying through community organisations and partnership development, without civil protest or other forms of political action, those with power-over economic and political decisions would have little reason to listen. Individuals progress along the continuum from a position of personal action to a point where they are collectively involved with redressing the deeper underlying causes of their concern through social and political action”. Thus, although this level is an extension of the previous level it is this political action, to successfully redistribute resources and decision-making, that differentiates community empowerment from individual and organisational empowerment and from other approaches such as community development and

community capacity building. This action to achieve social justice and equity is associated with a sense of liberation and struggle as it must be seized from those already holding power (Stevenson and Burke, 1991; Labonte, 1994).

#### **3.1.4 Operational factors**

The five-point continuum presented above describes the process by which individuals progress from a position of concern about a specific and personal issue to a point where they are involved in redressing the deeper underlying causes of the lack of equity and social justice through collective social and political action (Laverack, 1999). Two categories of factors have been identified with the potential to strengthen or weaken this process of community empowerment. First, contextual or descriptive factors such as political, economic, historical and socio-cultural circumstances. These factors should be recognised but, in reality, community empowerment programmes can have little effect on them (Rifkin, 1990).

Second, operational or action factors such as the organisational areas of influence. These represent those aspects of the process of community empowerment that allow individuals and groups to mobilise and organise themselves to harness the interpersonal elements that arise from each stage of the community empowerment continuum - such as individual control, social capital and community cohesiveness - and bring them to bear on the contextual elements of community empowerment - such as the political, socio-cultural and economic - through social and political change (Laverack, 1999). In themselves they may act as proxy measure for the social aspects of community empowerment (Laverack, 1999).

A number of different theorists have identified operational factors of relevance to community empowerment. These include (figure 3c - page 107): Rifkin et al (1988) in their factors influencing community participation, Eng and Parker (1994) in their dimensions influencing community competence, Shrimpton (1995) in his indicators of community participation, Goodman et al (1998) in their dimensions integral to community capacity, Bopp et al (1999) in their dimensions of community capacity, Woodward et al (1999) in their dimensions of community capacity, Laverack (1999) in his domains that influence the process of community empowerment, and Gibbon (1999) in her identification of community capacity domains. In contrast to contextual factors, operational factors are relevant in a programme context. Their purposeful integration into programmes can drive individuals, organisations and communities along the community empowerment continuum.

*Table 3c: Operational factors that influence community participation, community competence, community capacity and community empowerment*

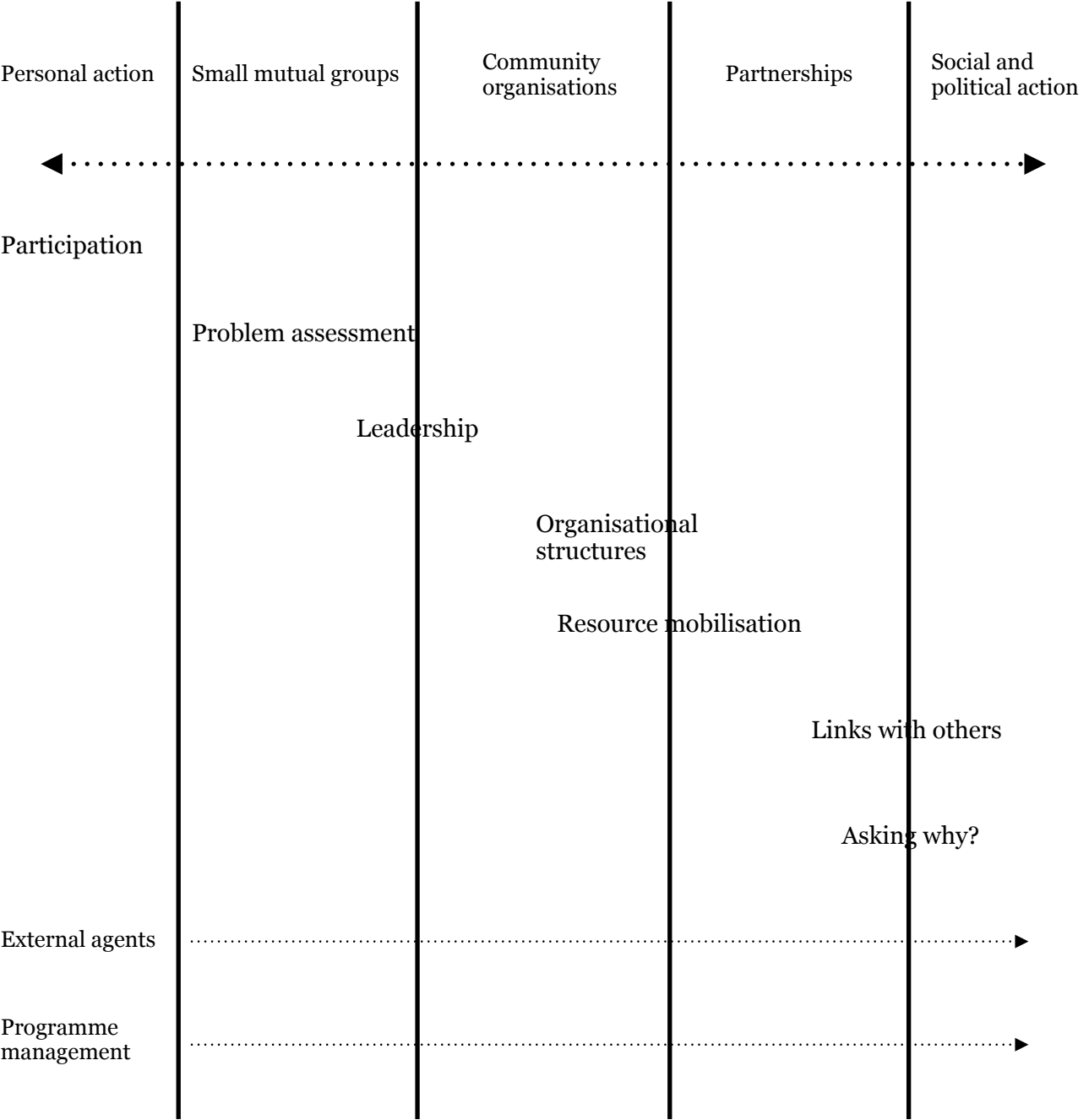
<b>Rifkin (1988)</b>	<b>Eng and Parker (1994)</b>	<b>Shrimpton (1995)</b>	<b>Goodman et al (1998)</b>	<b>Bopp et al (1999)</b>	<b>Woodward et al (1999)</b>	<b>Laverack (1999)</b>	<b>Gibbon (1999)</b>
-	Participation	-	Participation	Participation	Effective participation	Participation	Representation
Leadership development	-	Leadership	Leadership	Leadership	Leadership	Local leadership	Leadership
Assessment of needs	-	Needs assessment	Skills	Shared vision	Knowledge and analysis	Problem assessment	Needs assessment
Community organisation	Social support	Organisation	Sense of community, understanding of community history, community values	-	Viable structures	Organisational structures	Organisation
Resource mobilisation	-	Resource mobilisation	Resources	Communication, resources, knowledge, skills	Resource mobilisation	Resource mobilisation	Resource availability
-	Self awareness	-	Critical reflection	Ongoing learning	Reflection	Asking why?	Implementation
-	Management of relations with others	-	Networks	-	Relationship building	Links with others	Linkages
-	-	-	-	-	Outside agent	External agents	-
-Programme management	-	Programme management	-	-	Knowledge and analysis	Programme management	Management

The following description of operational factors explores these different conceptualisations with particular reference to the work of Laverack (1999; 2000; 2001a; 2001b; 2001c; 2001d; 2003; 2004; 2005a; 2005b; 2006; 2007a; 2007b; 2007c; 2009; 2010). Laverack (1999) carried out an extensive review of the community development, community empowerment and community capacity-building literature and explored those programmes seeking to bring about social and political change. His review identified nine common operational domains which community empowerment programmes seek to promote: participation, leadership, resource mobilisation, problem assessment, links with others, organisational structures, asking why, the role of outside agents, and programme management. Laverack (1999) summarised how these operational factors work to harness the interpersonal elements of community empowerment: “Organisations and small groups provide an opportunity for reflecting, sharing experiences and acting collectively. Through this process the organisation itself becomes strengthened, has better leadership, participation and a greater ability to mobilise itself and the resources of its members, thus becoming more productive in its goals or tasks. The organisation and its individual members, through this sense of accomplishment, also gain more control in the larger community, partly through greater influence on policy and decision-making achieved through improved links and partnerships with other organisations” (figure 3d - page 109).

Since these operational factors represent those factors that help individuals, organisations and communities to become ever more organised and mobilised, they enable individuals, groups and communities to progress along the community empowerment continuum from psychological empowerment to collective social and political action. In doing this they enable individuals, groups and communities to harness the interpersonal elements that arise out of the community empowerment process - to harness the benefits of organisation - and bring them to bear on the broader social determinants of their health. These operational factors can be acted upon directly by community empowerment programmes to achieve their objectives (Rifkin, 1990). To be effective, any community mobilisation programme concerned with empowering communities to address the broader determinants of health needs to promote these factors in the communities in which it is working. If they exist then a community can be considered capable or empowered and thus better able to exercise control over the social determinants of MCH. If they are absent then a community is not empowered and is unable to exercise control over the social determinants of MCH. Thus, logically, the operational factors represent the qualities of an empowered community and can provide a means of understanding the way in which community empowerment programmes start with individuals, progress through a group process and ultimately have an influence on the broader determinants of health.



Figure 3d: Relationship between operational domains and stages of community empowerment continuum (adapted from Laverack, 2005)



## **Participation of community members**

Participation arises out of personal action and helps to mobilise and organise communities into small mutual groups.

Personal action can help to develop capacities such as personal efficacy and a sense of mastery and control and thus generate a spirit of initiative and self-reliance (Rifkin, 1990). It can also include developing skills and motivations to participate. It is through participation that individuals can draw on these capacities and take their first steps towards achieving wider community empowerment objectives. Participation is thus an outcome of personal action and is also basic to community empowerment as it describes the involvement of community members in groups and activities that influence their health and are key in moving them along the continuum to social and political action.

Participation is theorised to occur at five different levels: in the programme's benefits, in its activities, during implementation, in programme monitoring and evaluation, and in programme planning (Rifkin, 1990). However, ultimately, participation is the choice of the individual and may be associated with their sense of community, their perceptions of the costs and benefits of participation, their expectancies of individual and collective control and their degree of concern about the issue at hand (Goodman et al, 1988).

## **Problem assessment capacities of communities**

Problem assessment capacities arise out of small mutual groups and helps to mobilise and organise communities into community organisations.

It is through groups that individual knowledge about problems and solutions can be collectivised, shared and validated. Furthermore, if identification of problems, solutions and actions is undertaken by the community itself then there is a great potential for empowerment (Tonon, 1980; Pelletier and Jonsson, 1994; Plough and Olafson, 1994; Purdey et al, 1994; Laverack, 1999). However, the identification of community problems and potential solutions requires a high level of skill and although many programmes recognise the importance of community involvement, it is often limited and the relevant skills are not developed. This reduces community commitment and hinders the development of community organisations since a sense of ownership over problems and solutions does not develop. Indeed, Laverack (1999) stated that programmes that do not address community concerns or involve the community in the process of problem assessment do not usually achieve their purpose. Furthermore, Rifkin (1990) claimed that for needs assessment to be successful the community should not focus on identifying health problems as a priority. Although these problems may form the focal point for activities, other community issues should also be identified and addressed.

## **Local leadership in communities**

Local leadership arises out of small mutual groups and helps to mobilise and organise communities into community organisations and partnerships.

Effective leadership cannot develop without a strong participant base. Equally participation in and development of larger community organisations is hindered without effective leadership because they take responsibility for getting things done, deal with conflict, provide direction for the group and ensure breadth and representativeness of participation (Laverack, 1999; Rifkin, 1990). If leaders are able to ensure the active involvement of diverse network of community members then community organisations develop, formalise and become institutionalised and maintained (Steuart, 1985; Rifkin, 1990). It is through good leadership these community organisations enable the individuals with disparate interests to take collective action.

The formation of groups and organisations is facilitated by leaders with connections to leaders in other groups and organisations. The appropriateness of the leader and their leadership style and skills also both influence the development of groups and community organisations and the extent to which the participant base necessary for their survival is maintained (Goodman et al, 1988; Costantino-David, 1995; Rifkin, 1990). Finally, participation in these groups and organisations is maximised if the leaders remove barriers and are responsive and accessible to participants (Goodman et al, 1998).

## **Organisational structures in communities**

Organisational structures arise out of community organisations and help to organise and mobilise community members into partnerships and to take social and political action.

Organisational structures arise out of community organisations and their existence and level at which they function is crucial to community empowerment (Laverack, 1999). These structures have an organisational and social element. The organisational element represents the ways in which people come together to socialise, identify their problems and solutions and plan and undertake actions to address these concerns (Laverack, 1999). The social element represents the sense of cohesion amongst members including their concern for community issues, their sense of connection to the people of the community and their feelings of belonging (Laverack, 1999). Goodman et al (1998) states that these social elements are closely connected to the dimensions of sense of community, understanding of community history and clarity of community values. Organisational structures enable community organisations to harness their potential, for example their established structure, functional leadership, organisational and resource mobilisation abilities, and use this to form partnerships that look beyond the immediate concerns of their members to the broader issues that underpin their needs. Organisational structures are thus indicators of community support for and ability of

community organisation and form the basis for active collaboration between community organisations to form partnerships (Rifkin, 1990).

### **Resource mobilisation abilities of communities**

Resource mobilisation abilities arise out of community organisations and help mobilise and organise communities to form partnerships and take social and political action.

The ability of the community to mobilise resources and use them prudently is an indication of a high degree of community skill and organisation and a key factor towards empowerment (Fawcett et al, 1995; MaCallan and Narayan, 1994; Barrig, 1990; Hildebrandt, 1996; Goodman et al, 1998). Resources can be conceptualised as internal (raised from within the community) and external (brought in from outside the community) or 'traditional capital' (for example, property and money) and 'social capital' (for example, trust and cooperation). 'Social capital' resources, which arise from positive community organisation experiences, are particularly important as they allow people and organisations to come together and develop new and varied relationships and thus help in the development of partnerships and addressing social problems.

### **Links of communities with other people and organisations**

Links with others arise out of partnerships and help organise and mobilise communities to take social and political action.

Links with others include interpersonal and organisational networks and relationships that arise from within the context of community organisational structures such as partnerships, coalitions and alliances formed to address community problems. Organisational connections are particularly useful for community empowerment for health related goals (Israel et al, 1994). They promote individual empowerment by allowing for greater community information, cooperative decision-making and involvement in planning, implementation and evaluation of programmes (Laverack, 1999). They also promote community empowerment to address social issues by more efficiently pooling resources and expertise, encouraging exchanges of services, pursuit of joint ventures based on a shared goals and advocacy initiatives to change policies (Israel et al, 1994; Goodman et al, 1998). As the number and size of linkages increases so the frequency and intensity of contacts and benefits of the links multiply.

### **Ability of community to ask why**

The ability to ask why arises out of partnerships and helps organise and mobilise communities to take social and political action.

When communities come together in partnership with other communities and organisations they have the opportunity to engage in group dialogue beyond the immediate local problems and causes to a critical assessment of the contextual causes of their ill health. This dialogue has

been termed 'dialectical thinking' and is characterised by welcoming contradictions, paradoxes and the presumption of constant change in communities (Goodman et al, 1998). The resultant heightened awareness of the forces in the environment that lead to the group's disempowerment forms the basis for the planning and implementation of more effective strategies to change the circumstances of their disempowerment and bring about individual, social and political change. As a result, a 'praxis' cycle forms as the actions lead to further contradictory outcomes which undergo collective reflection to develop new actions. When the cycle reaches a stage at which people are making connections between themselves and the broader social context, are reflecting on their own roles in society, are understanding the history and conditions of the social problem they face, and are believing they can participate in collective change, they have reached a stage of 'critical consciousness' (Goodman et al, 1998).

### **Equitable relationships with external agents and community control over programme management**

Equitable relationships with outside agents and control over programme management arise from each stage of the community empowerment continuum and help mobilise and organise communities in relation to each stage.

The previous seven domains are generic and could be applied in any community, either as part of or independent from the programme context (Laverack, 1999). However, two domains are specific to the development of community empowerment in a programme context and thus have influence across all stages of the community empowerment continuum. At each stage of the continuum the extent and quality of engagement in personal action, small mutual groups, community organisations, partnerships and social and political action, and thus the movement of the community along the continuum, is mediated by the role of the external agent and the role of the community in programme management.

The role of the external agent and the issue of who manages the programme are two sides of the same coin. As external agents increasingly share control of the programme and its resources with the community so the extent of management of the programme by the community increases.

At the beginning of a programme the relationship between the community and external agents is often necessarily not equitable and the community may have little control over programme management. However, as the programme evolves the external agent should transform their 'power-over' decisions and resources to increasingly allow the community to discover their 'power-from-within' and take more responsibility, ownership and control (Laverack, 1999). Each of the stages along the community mobilisation continuum can assist in this transformation by increasingly equalising the relationship between the community and the external agent and increasing the control of the community over programme management by

developing their capacities in: infrastructure (Cosantino-David, 1995), skills (Minkler and Cox, 1980), critical consciousness (O’Gorman, 1995), technical expertise (Hildebrandt, 1996), and finances (Wheat, 1997). In turn, development of these capacities can lead to the next stage of the community empowerment continuum as the community becomes more capable and organised.

For example, let us consider the transition from small mutual groups to community organisations. As discussed above, small mutual groups promote the development of problem assessment and leadership capacities of communities. At the beginning of a programme it may be necessary for the external agent to have a greater role in the assessment of problems and identification of leaders since small groups may lack the necessary skills and motivation. However, the potential of these capacities is maximised if the external agent develops the problem assessment and leadership skills and opportunities of the small groups. This is best achieved if the external agent takes an ‘enabling’ role characterised by non-coercive dialogue in the identification and resolution of problems, lending professional status to give credibility and using their power-over to strengthen community and individual autonomy (Laverack, 1999). The potential of leadership and problem assessment capacities is further maximised if the small groups are given more responsibility and independence over all decisions related to problems and leadership. As discussed above, the presence of these problem assessment and leadership capacities will in turn lead to the development of small mutual groups into community organisations.

### **3.2 How do community mobilisation interventions enable communities to address the SDH?**

#### **3.2.1 Existing evidence of the socio-environmental mechanism through which community mobilisation interventions might be enabling communities to address SDH**

The 11 type IV and V community mobilisation interventions identified in chapter 2 were reviewed again, within the framework of the nine community empowerment domains model presented above, to explore how they might be enabling communities to address the SDH (table 3e - page 115 to 120). Of the 11 interventions, MaiMwana Project was excluded from this review as it is the focus of this thesis and the way in which it is addressing the SDH will be presented in chapter 5, 6 and 7. Furthermore, the MIRA Dhanusha and SNEHA interventions were not reviewed as their evaluation results are not yet available.

Reviewing the remaining eight interventions revealed that two presented evidence relevant to the physiological mechanisms through which the interventions might be working, all eight presented evidence of relevance to the behavioural mechanisms and six presented evidence of relevance to the socio-environmental mechanism through which they might be addressing the

SDH. The six interventions with this evidence are: CWO, Nigeria; CCCSARS, Canada; CMI, India; Ekjut Project, India; Entabeni Project, South Africa; and Sonagachi Project, India.

Although evidence from all these six of these interventions was considered they suffer from three limitations. First, the way in which they were addressing the SDH, and thus bringing about desired changes in health, was only explored specifically in three of the interventions: Ekjut Project, Entabeni Project, and Sonagachi Project. Second, although rigorous, these three evaluations were small scale, retrospective and did not frame their explorations using the nine domains model or any other specific theory of empowerment. Finally, only information, that could be extracted from the published articles detailed in chapter 2, has been included here.

The nine domains of community empowerment are evident in discussions of how these interventions might be empowering communities to address the SDH. These interventions appear to trigger the participation of community members in activities to address their problems. Evidence for this is available for five of the interventions. For example, in CCCSARS the community participated in SARS prevention activities such as meetings and volunteering on a telephone helpline (Dong et al, 2010).

Once a participant base was established, it appears that leaders start to emerge to drive the activities forwards. Evidence for this is available for all six interventions. In some cases these leaders appear to evolve naturally through the intervention process, while in others they are identified and trained by the external agent. An example of the former is CWO where representatives and delegates were elected by the group participants to attend external meetings (Ilika and Ilika, 2005). An example of the latter is CMI where change agents were identified, by the external agent, from amongst local FSWs and trained as peer educators and community organisers (Blankenship et al, 2010).

The leaders then helped to coordinate the communities to engage in an assessment of their needs. Evidence for this is available for three of the interventions. For example, in Ekjut Project, women's group participants discussed the difficulties they faced and practical ways to collectively address them (Rath et al, 2010).

Organisational structures started to form around the identified needs to help address the shared concerns in these communities. Evidence for this is available for five of the interventions. In some cases these structures were formed by the communities themselves while in others they were formed by the external agents. An example of the former is CCCSARS which is a coalition of Chinese-Canadian organisations formed by the community itself to help address the SARS outbreak (Dong et al, 2010). An example of the latter is Ekjut Project where the external agent encouraged and supported the formation of women's groups (Rath et al, 2010).

Capacities built through the organisational structures enabled communities to start to mobilise resources necessary to address their problems. Evidence for this, or the lack of this activity, is available for five of the interventions. For example, in Entabeni Project the community was struggling to sustain the project because it was failing to mobilise support from partners and funds for volunteer incentives (Campbell and Cornish, 2010a).

As communities mobilised resources they became more aware of and started to ask why they suffered from their problems and started to explore the root causes of these problems. Evidence for this is available for two of the interventions. For example, in Ekjut Project participants developed critical consciousness of the root causes of their ill health and the capacity to deal with health and development difficulties arising from poverty and social inequalities by challenging actors responsible for perpetuating them (Rath et al, 2010).

To help to address the root causes of their problems, the communities started to link with other individuals, groups and organisations. Evidence for this is available for four of the interventions. For example, in Sonagachi Project the communities built strong and supportive relationships with outside actors and agencies including politicians, police and journalists (Campbell and Cornish, 2010a).

The capacities of communities to participate, lead, assess needs, organise, mobilise resources, ask why and link with others were built by external agents. Evidence for this is available for three interventions. For example, in Ekjut Project training and a support structure was provided to women's group facilitators who were guiding their communities in their activities to address MCH issues (Rath et al, 2010).

As the capacity of communities to participate, lead, assess needs, organise, mobilise resources, ask why and link with others increased so they gradually took control of the interventions. Evidence for this is available for four of the interventions. For example, in Sonagachi Project the women gradually became more involved and they eventually took over decision-making responsibilities (Campbell and Cornish, 2010a).



Table 3e: Evidence of how 11 community mobilisation category IV and V form interventions might be enabling communities to address the SDH

Intervention	Evidence of impact	Explanation of impact
<b>Catholic Women's Organisation (CWO), Nigeria</b>	Modification of widowhood practices and elimination of dehumanising practices. 100% adherence to CWO resolutions on widowhood rites over the first year since the resolutions were agreed.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Changes in widowhood practices.</p> <p><i>Socio-environmental mechanism:</i> Empowerment of community to tackle gender rights issues through - involvement of catholic women (<b>participation</b>); meetings attended by representatives and delegates from zones within and outside the community (<b>leadership</b>); formation of CWO and the central executive group (<b>organisational structures</b>); identification of dehumanising practices (<b>needs assessment</b>) and gender issues underlying these (<b>asking why?</b>) by community members; networking and advocacy with leaders and other women's groups (<b>links with others</b>); soliciting support and encouragement from others (<b>resource mobilisation</b>); and involvement of community in decision-making about all aspects of the programme (<b>programme management</b>).</p>
<b>Community Coalition Concerned about SARS (CCCSARS), Canada</b>	SARS combatted and healthcare system more effective at responding to public health challenge of SARS and the diverse needs of the community.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Increased awareness of SARS related issues. At risk individuals being referred to and seeking appropriate medical care.</p> <p><i>Socio-environmental mechanism:</i> Empowerment of Chinese community to take control of their environment through - <b>participation</b> of community in activities; active <b>leadership</b> in public health issues; formation of coalition (<b>organisational structures</b>); collective problem solving (<b>needs assessment</b>); <b>mobilisation of resources</b> and funds; and community has control over decision-making (<b>programme management</b>).</p>

Intervention	Evidence of impact	Explanation of impact
Community Mobilisation Intervention (CMI) within the Avahan AIDS Initiative, India	Exposure to the CMI is associated with increased condom use and increased awareness and active utilisation of the Avahan India AIDS Initiative.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Awareness and utilisation of Avahan intervention.</p> <p><i>Socio-environmental mechanism:</i> Building of collective power of FSWs through - encouraging FSWs to come together to enhance their power (<b>participation</b>); identifying and training social change agents amongst local FSWs to be peer educators and community organisers (<b>leadership</b>); encouraging formation of community-based organisations comprised of and led by FSWs (<b>organisational structures</b>); and engaging with leaders and other community groups (<b>links with others</b>).</p>
Ekjut Project, India	NMR 32% lower in intervention clusters compared to control clusters. 57% reduction in moderate maternal depression.	<p><i>Physiological mechanism:</i> Reduction in septicaemia, birth asphyxia, hypothermia and prematurity.</p> <p><i>Behavioural mechanism:</i> Increased knowledge, awareness and problem solving skills. Changes in hygiene and home-care practices.</p> <p><i>Socio-environmental mechanism:</i> Capacity and confidence building through - good <b>participation</b> and inclusion of women and other community members in the process; facilitation of the process by trained, local women and group members becoming active health advocates in their communities (<b>leadership</b>); establishment of women's groups (<b>organisational structures</b>); sharing difficulties faced and practical ways to collectively address them (<b>needs assessment</b>); developing critical consciousness of root causes of ill health and thus capacity to deal with health and development difficulties arising from poverty and social inequalities by challenging actors responsible for perpetuating them (<b>asking why?</b>); involvement of the wider community (<b>links with others</b>); garnering support from wider community (<b>resource mobilisation</b>); provision of training and support structure for facilitators (<b>external agents</b>); and engagement of community members as designers, implementers and recipients (<b>programme management</b>).</p>

Intervention	Evidence of impact	Explanation of impact
<b>Entabeni Project, South Africa</b>	Increased confidence and profile of volunteers, increased technical knowledge and skills of volunteers, increased effectiveness of nursing support and increased participation of local church leaders. Failure to build a supportive social environment.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Built skills and knowledge about HIV/AIDS. Changes in sexual behaviour.</p> <p><i>Socio-environmental mechanism:</i> Failed to adequately build the capacity of poor rural women to deliver effective care through - failing to develop women as <b>leaders</b>; only succeeding in linking to two small NGOs and no real links to public sector and welfare agencies (<b>links with others</b>); failing to mobilise support from partners and funds for incentives for volunteers (<b>resource mobilisation</b>); and training of women (<b>external agent</b>).</p>
<b>MaiMwana Project, Malawi</b>	MMR 23% lower in intervention clusters compared to control clusters. PMR, NMR and IMR lower but not significant.	<p><i>Physiological mechanism:</i> Results not yet available.</p> <p><i>Behavioural mechanism:</i> Increased ANC uptake, skilled birth attendance, complete immunization at six months, exclusive breastfeeding rates and early initiation of breastfeeding rates. Reduction in births attended by TBAs and use of pre-lacteals.</p> <p><i>Socio-environmental mechanism:</i> The focus of this thesis and presented in detail in chapter 5.</p>
<b>Mother and Infant Research Activities (MIRA), Dhanusha, Nepal</b>	Results not yet available.	Results not yet available.

Intervention	Evidence of impact	Explanation of impact
<b>Mother and Infant Research Activities (MIRA), Makwanpur, Nepal</b>	NMR 30% lower in intervention clusters compared to control clusters.	<p><i>Physiological mechanism:</i> Reduced infection rates.</p> <p><i>Behavioural mechanism:</i> Increased knowledge of prenatal issues and changes in home-care and care-seeking practices.</p> <p><i>Socio-environmental mechanism:</i> NA</p>
<b>Perinatal Care Project (PCP), Bangladesh</b>	No significant reduction in NMR in intervention clusters compared to control clusters.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Changes in home-care and care-seeking practices.</p> <p><i>Socio-environmental mechanism:</i> NA</p>
<b>Society for Nutrition, Education and Health Action (SNEHA), India</b>	Results not yet available.	Results not yet available.
<b>Sonagachi Project, India</b>	Increased condom use, decreased sexually transmitted infections and empowerment of sex workers. Succeeded in building a supportive social environment.	<p><i>Physiological mechanism:</i> NA</p> <p><i>Behavioural mechanism:</i> Built skills and knowledge about HIV/AIDS. Changes in sexual behaviour.</p> <p><i>Socio-environmental mechanism:</i> Built capacity of impoverished and excluded sex workers to take control of sexual health through - <b>participation</b> of sex workers in delivering health education and advocacy; effecting gradual involvement of women in decision-making (<b>programme management</b>) and <b>leadership</b>; establishment of a cooperative bank for sex workers (<b>organisational structures</b>); building of strong supportive relationships with outside actors and agencies including politicians, police and journalists (<b>links with others</b>); mobilising support and resources from partners and economic empowerment through small payments to peer educators and establishment of micro-credit and saving schemes (<b>resource mobilisation</b>); and training of sex workers (<b>external agent</b>).</p>

### **3.2.2 The socio-environmental mechanism**

On the whole, social interventions are viewed in terms of effects, with little attention paid to how those effects might be produced. In this way, how social interventions work is often conceptualised as a box, containing intermediate activities, that stands between the initial conditions and the finish conditions (Machamer et al, 2000). In most cases this box is considered to be a 'black box' because almost nothing is known about the inner workings.

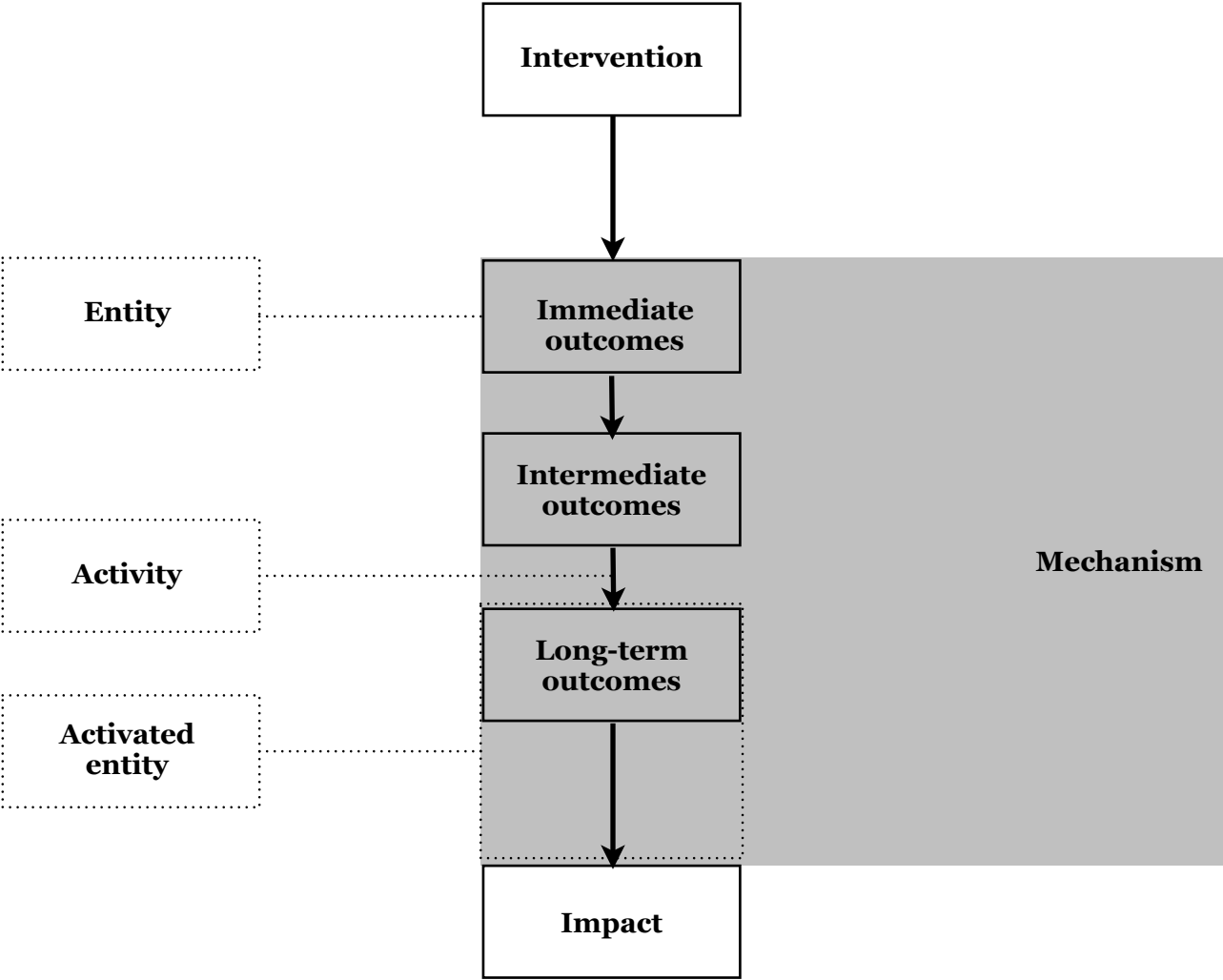
The evidence presented above partially illuminates the socio-environmental mechanism through which community mobilisation interventions might be empowering communities to address the SDH. However, at best, this information has made the 'black box' a 'grey box' where the intermediate components of the socio-environmental mechanism - the nine domains - can be discerned but not the principles of logic of their operation. A 'white box' intervention is one where the principles and logic of the operation of these components are transparent (Scriven, 1994). In other words, where the inner workings of the socio-environmental mechanisms have been illuminated.

But, what do these inner workings consist of? Substantively speaking, mechanisms state how, by what intermediate steps, a certain impact follows from an intervention (Mayntz, 2004; Pawson and Tilley, 1997). This is based on an understanding that it is not an intervention itself that works but how the resources the intervention offers are interpreted and acted upon and thus enable individuals to make it 'work' (Pawson and Tilley, 1997). The intermediate steps in this process are conceptualised to consist of entities and activities sitting between start or setup and finish or termination conditions (Machamer et al, 2000). As such, mechanisms are dualistic in nature in that they interdependently consist of both entities and activities (Pajunen, 2005). Entities represent the elements in mechanisms and often include intervention activities, immediate outcomes, intermediate outcomes, and long-term outcomes (Donaldson, 2007; Donaldson and Lipsey, 2006; Lipsey et al, 2004) (figure 3f - page 123). Intervention activities represent the actions undertaken by the programme to bring about a desired end. Outcomes represent the anticipated changes in participants that result directly or indirectly as a result of the inputs, activities and outputs. Immediate outcomes are usually expressed as changes in knowledge, skills, abilities and other characteristics. Intermediate outcomes are usually classified as behavioural changes that follow the immediate knowledge and awareness changes. Long-term outcomes refer to more global changes such as community impacts and are produced as a result of the intermediate outcomes. Mechanism activities, on the other hand, represent what these entities do. An activated entity, then, forms a functional component or a role function of a mechanism (Craver, 2001, Cummins, 1975). Mechanisms are thus sequences of linked activated entities that occur repeatedly if certain conditions are given (Mayntz, 2004). A combination or configuration of these components, as a whole, forms the productive account of a mechanism (Pajunen, 2005). It is important to highlight that although the causal structure of mechanisms can be linear it is often much more complex (Mayntz, 2004).

Describing a mechanism is particularly complicated as they, and their component entities and activities, are hidden. A common metaphor to describe the underlying and hidden nature of mechanisms is that of a clock. To understand how a clock works it is necessary to explore beyond the surface - the clock-face - and delve into the hidden, inner workings (Pawson and Tilley, 1997). Indeed mechanisms are proposed to operate at the deepest of three levels (Bhaskar, 1997). The first level is the 'empirical' and it consists of what we can experience directly and indirectly; the clock face. The second level is the 'actual' where things happen whether we experience them or not; the cogs and wheels. The deepest level is the 'real' where the forces and mechanisms that produce events in the real world exist; the oscillation of caesium atoms. By exploring this deepest level it is possible to move beyond thinking about the empirically observable individual variables and the links between them to considering the bigger picture of hidden, empirically unobservable action in its entirety (Anderson et al, 2006).

The fact that mechanisms are hidden and thus not directly empirically observable does not mean they are not 'real'. As Sayer (2000) stated it is possible to make a plausible case for the existence of underlying mechanisms by referring to observable effects which can only be explained as products of underlying mechanisms. However, they do require 'surfacing', which involves exploring and specifying a clear causal generalisation of the processes linking an outcome and specific initial conditions. In other words specifying a mechanism statement. As a result, the term 'mechanism' is used both to designate a certain class of real, although hidden, phenomena (mechanisms are such and such, they do such and such) and to designate a class of propositions or generalisations referring to such phenomena which can be surfaced through research (Mayntz, 2004). Surfacing, as a form of enquiry, has been termed 'retroduction' or 'principled discovery' and involves shuttling between theory and empirical data using both inductive and deductive reasoning (Bhaskar, 1975; Mark et al. 2000). The grounded theory approach described in chapter 4 is one methodology that can help to achieve this.

Figure 3f: Components of a mechanism of an intervention



### **3.3 The MaiMwana Project women's group intervention as an example of the socio-environmental mechanism through which community mobilisation interventions address the SDH**

The discussion in the previous section suggests two things. First, that there is little information available, for community mobilisation category IV and V form interventions, regarding the precise mechanism through which they might be empowering communities to address the SDH. Second, it suggests that a full understanding of how community mobilisation empowers communities to address the SDH should start with carefully surfacing the sequences of linked activated entities that make up the socio-environmental mechanism.

The MaiMwana Project women's group intervention offers the potential to surface these socio-environmental mechanisms. First, as discussed in chapter 2, it is an example of a community mobilisation type IV intervention. Second, as presented in this chapter it has been successful in reducing the mortality of women and children in rural Malawi (Lewycka et al, Submitted). Finally, the socio-environmental mechanism through which it enables communities to address the SDH has been the subject of an extensive prospective process evaluation carried out since it was initiated and integrated with a rigorous impact evaluation (Lewycka et al, 2010).



## **Chapter 4: Methodology**

### **4.1 Thesis aim and objectives**

#### **4.1.1 Aim**

This thesis is concerned with surfacing the socio-environmental mechanism through which community mobilisation approaches improve health and reduce mortality.

#### **4.1.2 Objectives**

To achieve the aim, this thesis will explore how the MaiMwana women's group intervention in Mchinji District, Malawi, enables communities to take control of the SDH and thus reduce maternal and child morbidity and mortality. More specifically:

- To describe the activities provided by the MaiMwana women's group intervention
- To explore the capacities built by the intervention to help community members to organise and mobilise themselves to take action to improve MCH and reduce mortality
- To explore how community members organise and mobilise themselves to take action to improve MCH and reduce mortality
- To explore the interpersonal resources and relationships generated as the community members organise and mobilise themselves and that they can draw on to take action to improve MCH and reduce mortality

### **4.2 The MaiMwana women's group intervention**

MaiMwana Project was established in Mchinji District, Malawi, in 2003. The project is a collaboration between the Malawi Ministry of Health and the UCL Centre for International Health and Development. The primary project donors are Saving Newborn Lives (US), The Wellcome Trust (United Kingdom (UK)) and The Department for International Development (UK). It was established with the aim of improving MCH and reducing mortality by implementing and evaluating two community based health promotion interventions. The interventions include community mobilisation through women's groups which seek to empower communities to take control of their MCH issues; and peer health education by volunteer counsellors which seeks to increase knowledge of and change attitudes and behaviour towards infant feeding and care. The effectiveness of these two interventions on maternal and child mortality, morbidity and behaviour has been rigorously evaluated through a factorial cluster randomised controlled trial (Lewycka et al, 2010; Lewycka et al, Submitted).

The single descriptive ASTOR format (Hickson, 1999) was used to frame a description of women's group community mobilisation intervention (Rosato et al, 2010). This will describe: its purpose (Aims), the context in which it took place (Setting), the people whom it chiefly sought to influence (Target group), the specific events that took place during its life

(Objectives), and what needed to be put in to it so that it achieved its intended outcomes (Resources). This will serve as a description of the activities that the intervention is undertaking to address the SDH.

#### **4.2.1 Aims**

The aim of the women's group intervention is to build the capacities of communities to take control of MCH issues. In particular the high levels of disadvantage and disempowerment that underpin mortality and morbidity and inadequate practice of appropriate care and care-seeking behaviours.

#### **4.2.2 Setting**

##### **Malawi**

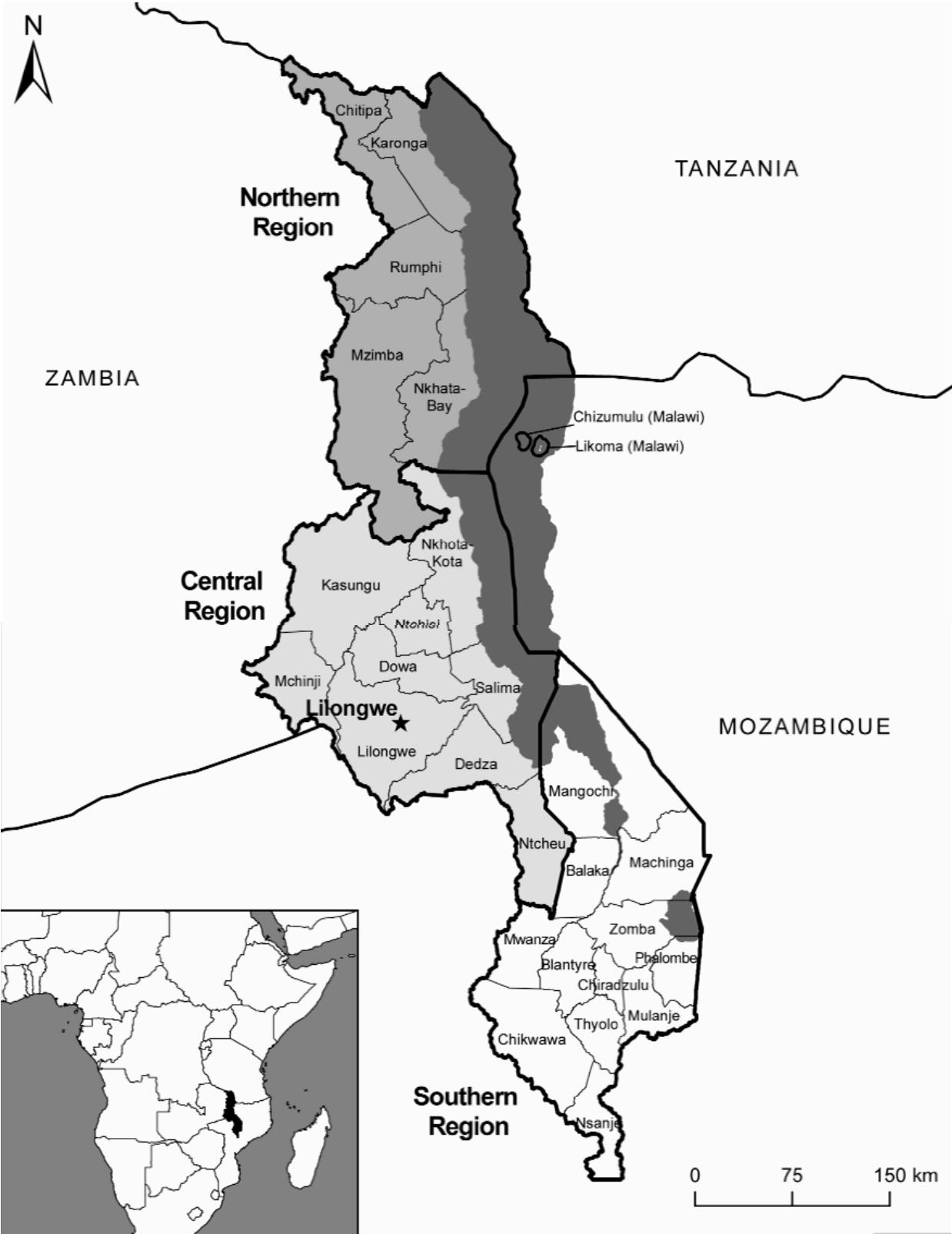
Malawi is a country south of the equator in sub-Saharan Africa (figure 4a - page 127). It has borders with the United Republic of Tanzania (to the North and Northeast), the People's Republic of Mozambique (to the East, South and Southwest) and the Republic Zambia (to the West and Northwest). The total area of the country is 118,484 square kilometers of which 80% (94,276 square kilometers) is land area. The remaining 20% is composed of Lake Malawi, which runs down the eastern boundary with Mozambique. The national language throughout Malawi is Chichewa.

The country is divided into three regions: the Northern, Central and Southern regions. The country is further divided into 28 districts and these are further subdivided into Traditional Authorities (TAs) presided over by chiefs. Each TA is composed of villages, which are the smallest administrative units and are presided over by Village Headmen (VHs).

Malawi is 160 out of 182 countries in the Human Development Index (HDI) (United Nations Development Programme (UNDP), 2009), has a Gross National Product (GNP) of \$690 per capita (World Bank, 2006), 73.9% of the population live below the poverty line of less than \$1.25 per day and 90.4% of the population live below the poverty line of \$2 per day (World Bank, 2010). The life expectancy at birth for both men and women is 48 years (World Bank, 2010).

Over three quarters (78.0%) of the population of Malawi is aged between 5 and 64 (5 to 14 years of age - 27.8%; 15 to 64 years of age - 50.2%) (NSO, 2008). Only 7.4% of the population is aged under-1 year of age (NSO, 2008). The main ethnic group is the Chewa (32.6%). Other tribes found in smaller numbers include Lomwe (17.6%), Yao (13.5%), Ngoni (11.5%) and Tumbuka (8.8%) (NSO, 2008). Most Malawians are Christian (82.7%) and 13.0% are Muslim (NSO, 2008). Over a quarter of the population aged over five years of age has attended primary school (25.2%) but only 2.3% has attended secondary school and 0.2% higher education (NSO, 2008).

Figure 4a: Map of Malawi



The total population of Malawi in 2008 was 13,077,160 (NSO, 2008). In 2006 the crude birth rate was 43.9 per 1000 population and the total fertility rate was 6.3 births per woman, (UNICEF and NSO, 2006). Over 9 in 10 women (97.2%) attended ANC at least once during pregnancy, just over half gave birth in a facility (53.8%) and 32.7% attended PNC within 42 days of delivery (UNICEF and NSO, 2006).

The 2006 Multiple Indicator Cluster Survey (MICS) and 2010 Malawi Demographic and Health Survey (MDHS) reported the following mortality rates and ratios for Malawi:

PMR	= 40 per 1000 births (NSO and ICF Macro, 2010)
NMR	= 31 per 1000 live births (NSO and ICF Macro, 2010)
Post-neonatal Mortality Rate	= 44 per 1000 live births (UNICEF and NSO, 2006)
IMR	= 72 per 1000 live births (UNICEF and NSO, 2006)
Child Mortality Rate	= 64 per 1000 live births (UNICEF and NSO, 2006)
Under-5 Mortality Rate	= 140 per 1000 live births (UNICEF and NSO, 2006)
MMR	= 675 per 100,000 live births (NSO and ICF Macro, 2010)

### **Mchinji District**

Mchinji District is one of nine administrative districts in the Central Region of Malawi (figure 4b - page 129). Topographically, the Central Region is mainly a plateau, over 1000 metres high, and is the country's main agricultural area. Mchinji, lies to the west of Lilongwe, the capital city, and has international borders with Zambia and Mozambique. It covers an area of 3,356 square kilometres and has a population of 456,516 (NSO, 2008). The district is divided into 9 Traditional Authorities (TAs): Dambe; Kapondo; Mavwere; Mduwa; Mkanda; Mlonyeni; Nyoka; Simpasi; and Zulu. These TAs consist of a total of over 1000 villages. The district centre is Mchinji Boma, the site of the MaiMwana Project office, but about 80% of the population of Mchinji live in rural areas. The main crops cultivated are maize, tobacco and groundnuts.

Figure 4b: Map of Mchinji District



Half the population of Mchinji (49.4%) is aged between 15 and 64 years of age (NSO, 2008). Most of the population is Christian (93.6%) and the other main religious group is Muslim which accounts for 2.9% of the population (NSO, 2008). Just over a quarter of the population aged over five years of age has attended primary school (26.1%) but only 1.7% has attended secondary school and 0.1% higher education (NSO and ICF Macro, 2008).

Most women (98.5%) in Mchinji attend ANC at least once during their pregnancy, but only 57.7% of women deliver at a health facility (UNICEF and NSO, 2006). In the district 41.3% attended PNC within 42 days of delivery (UNICEF and NSO, 2006).

Data from the 2006 MICS Survey and Lewycka (2011) reported the following baseline mortality rates and ratios for Mchinji:

PMR	= 40 per 1000 births (Lewycka, 2011)
NMR	= 24 per 1000 live births (UNICEF and NSO, 2006)
Post-neonatal Mortality Rate	= 41 per 1000 live births (UNICEF and NSO, 2006)
IMR	= 65 per 1000 live births (UNICEF and NSO, 2006)
Child Mortality Rate	= 73 per 1000 live births (UNICEF and NSO, 2006)
Under-5 Mortality Rate	= 133 per 1000 live births (UNICEF and NSO, 2006)
MMR	= 469 per 100,000 live births (Lewycka, 2011)

Maternal and perinatal health care is provided by personnel from Health Centres as well as by Rural Hospitals and the District Hospital, though the quality is compromised by the severe shortage of personnel, low morale of the health providers, and irregular drug supplies. Mchinji has one district hospital (a first referral and secondary health facility), four rural community hospitals (one government and three managed by the Christian Hospital Association of Malawi), one maternity unit, six health centres that provide maternity care, two dispensaries and two private clinics that offer ANC. There are around 750 people per hospital bed. Traditional Birth Attendants (TBAs) are also available in most areas.

### **Women's group clusters**

The women's groups are being implemented within a cluster randomized controlled trial designed to assess the impact of the groups on maternal, perinatal, neonatal and infant mortality (Lewycka et al, 2010, Lewycka, 2011; Lewycka et al, Submitted). Mchinji's total population, excluding the population of main district town, Mchinji Boma, was divided into 48 equal sized clusters and from these, at the end of the 'baseline' period (end of December 2004)

a total study population of 146,623 from 692 villages and 37,235 households was selected. Women's groups are being implemented in 24 of these clusters: 12 of these clusters are receiving women's groups as the only intervention while the other 12 clusters are receiving both the women's group intervention and the volunteer infant care counseling intervention (figure 4c - page 132).

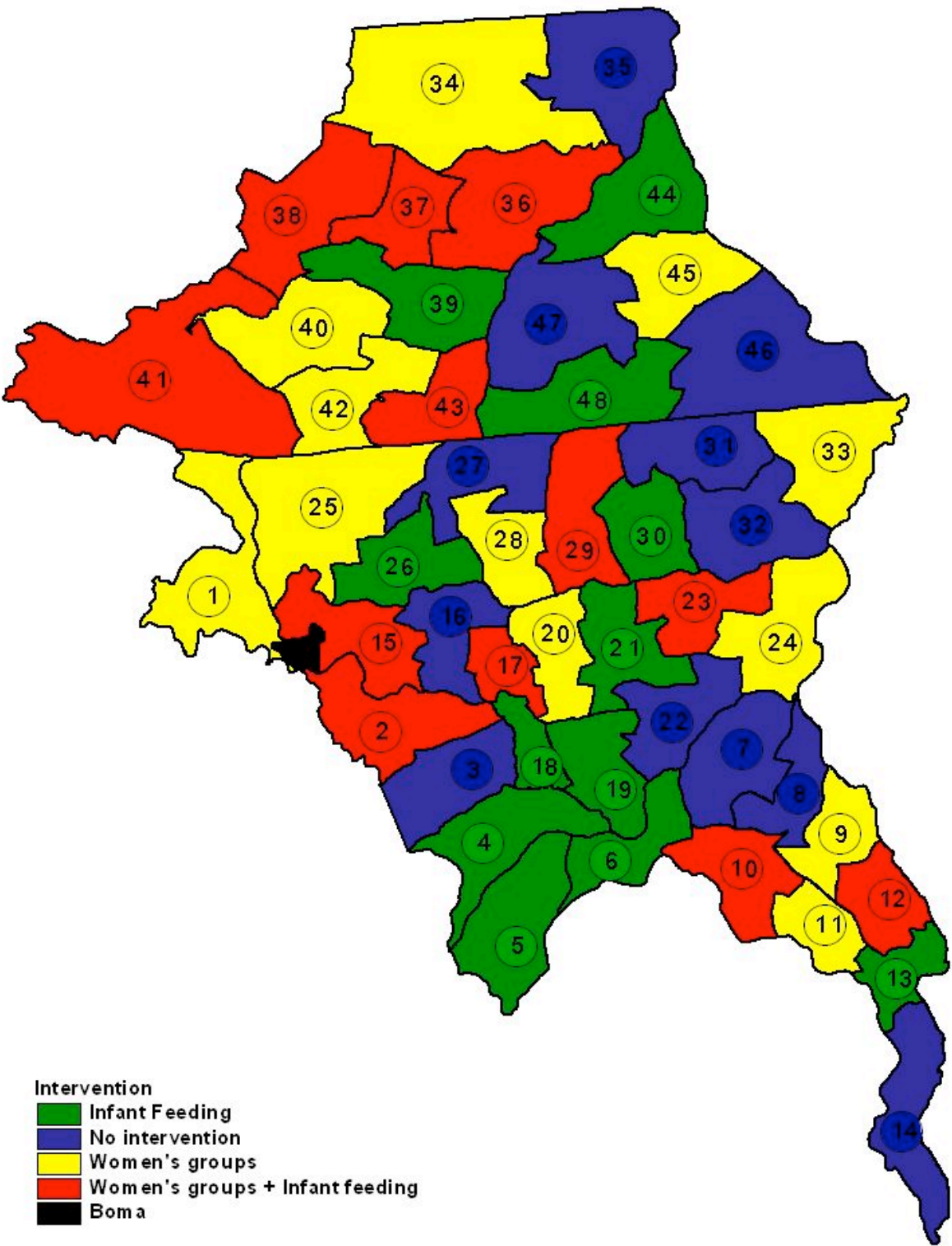
Within these 24 clusters there are 336 villages. Within these villages, at 'baseline' there was a total population of 72,129 people living in 18,350 households containing a total of 24,175 women aged between 10 and 49 years of age.

The majority of women (91.2%) in these clusters attended ANC at least once during pregnancy but only about one-third (36.1%) of women delivered in a health facility and one quarter (25.0%) attended PNC within 42 days of delivery (Lewycka, 2011).

Data from Lewycka (2011) reported the following mortality rates and ratios in women's group clusters at the end of the 'prospective baseline' period (January to June 2005):

PMR	= 50 per 1000 births
NMR	= 31 per 1000 live births
IMR	= 63 per 1000 live births
MMR	= 484 per 100,000 live births

Figure 4c: Map showing women’s group intervention clusters (yellow and red)





The data regarding Malawi, Mchinji and women's group clusters presented above comes from different sources that utilise different data collection methods and cover different time periods (table 4d - page 134 to 135). As a result, any comparison between national, district and women's group cluster setting data should be carried out with caution.

The data presented above suggests that Mchinji district and Malawi have similar age, religion and educational profiles. However, published data suggests that Mchinji has a much lower proportion of Muslims than the national average.

Rates of ANC attendance, facility delivery and PNC attendance within 42 days in women's group clusters are all lower than published figures for Mchinji and Malawi. In the case of facility delivery, in particular, and PNC attendance, to a lesser extent, these figures are much lower. However, the rates on the same indicators for women's group clusters compared to those for Mchinji district collected by MaiMwana Project at baseline using similar methods, are very similar.

The PMR in women's group clusters is much higher than the national rate from published sources and higher than the rate collected by MaiMwana Project at baseline using similar methods. The NMR for women's group clusters is similar to the rate from published sources for Malawi. It is a bit higher than the rate for Mchinji District from published sources but similar to the rate from MaiMwana Project data collected at baseline through similar methods. Both the IMR and the MMR are much lower in women's group clusters compared to published data for Malawi. However, the IMR for women's group clusters is the same as the rate for Mchinji District from published sources and much higher than the rate collected by MaiMwana Project at baseline, using similar methods.

Table 4d: Comparison of Malawi, Mchinji District and women's group clusters on key socio-economic, demographic and health indicators

		Malawi	Mchinji District		Women’s group clusters from MaiMwana Project data at baseline <sup>h</sup>
			Published statistics	MaiMwana Project data at baseline <sup>g</sup>	
POVERTY					
Human Development Index (HDI) <i>out of 182 countries</i>		160 <sup>a</sup>	-	-	-
Gross National Product (GNP) <i>US\$ per capita</i>		690 <sup>b</sup>	-	-	-
People living on less than \$1.25 per day <i>percentage</i>		73.9 <sup>c</sup>	-	-	-
People living on less than \$2 per day <i>percentage</i>		90.4 <sup>c</sup>	-	-	-
Life expectancy at birth <i>years</i>		48 <sup>c</sup>	-	-	-
KEY DEMOGRAPHIC CHARACTERISTICS					
Age <i>mean years</i>	Under 1	7.4	4.0 <sup>d</sup>	-	-
	1 – 4	14.3	14.8 <sup>d</sup>	-	-
	5 – 14	27.8	28.6 <sup>d</sup>	-	-
	15 – 64	50.2	49.4 <sup>d</sup>	-	-
	65 and over	3.8	3.2 <sup>d</sup>	-	-
Tribe <i>percentage</i>	Chewa	32.6	-	-	-
	Lomwe	17.6	-	-	-
	Yao	13.5	-	-	-
	Ngoni	11.5	-	-	-
	Tumbuka	8.8	-	-	-
	Other	16.0	-	-	-
Religion <i>percentage</i>	Christian	82.7	93.6 <sup>d</sup>	-	-
	Muslim	13.0	2.9 <sup>d</sup>	-	-
	Other	4.3	3.5 <sup>d</sup>	-	-
Highest educational level attended <i>percentage</i>	None	72.3	72.1 <sup>d</sup>	-	-
	Primary	25.2	26.1 <sup>d</sup>	-	-
	Secondary	2.3	1.7 <sup>d</sup>	-	-
	Higher	0.2	0.1 <sup>d</sup>	-	-
PREGNANCY AND BIRTH					
Antenatal care (ANC) at least once <i>percentage</i>		97.2	98.5 <sup>d</sup>	91.6	91.2
Facility delivery <i>percentage</i>		53.8	57.7 <sup>d</sup>	39.9	36.1
Postnatal care (PNC) within 42 days <i>percentage</i>		32.7	41.3 <sup>d</sup>	28.3	25.0

	Malawi	Mchinji District		Women’s group clusters from MaiMwana Project data at baseline <sup>h</sup>
		Published statistics	MaiMwana Project data at baseline <sup>g</sup>	
MORTALITY				
Perinatal Mortality Rate (PMR) <i>per 1000 births</i>	40 <sup>e</sup>	-	40	50
Neonatal Mortality Rate (NMR) <i>per 1000 live births</i>	31 <sup>e</sup>	24 <sup>f</sup>	26	31
Post-neonatal Mortality Rate <i>per 1000 live births</i>	44 <sup>f</sup>	41 <sup>f</sup>	-	-
Infant Mortality Rate (IMR) <i>per 1000 live births</i>	81 <sup>f</sup>	65 <sup>f</sup>	50	63
Child Mortality Rate <i>per 100,000 live births</i>	64 <sup>f</sup>	73 <sup>f</sup>	-	-
Under-5 Mortality Rate <i>per 100,000 live births</i>	140 <sup>f</sup>	133 <sup>f</sup>	-	-
Maternal Mortality Ratio (MMR) <i>per 100,000 live births</i>	675 <sup>e</sup>	-	469	484

<sup>a</sup> Human Development Report, 2009. UNDP.

<sup>b</sup> World Development Indicators, 2006. The World Bank.

<sup>c</sup> World Development Report, 2010. The World Bank.

<sup>d</sup> Malawi Population and Housing Census 2008. National Statistics Office, Malawi (NSO). The census was designed to provide estimates of, among other things, population size, age-sex composition, survival status, spatial distribution of population, literacy and population growth rates. The census team mapped 9,213 enumeration areas throughout Malawi. During the enumeration period enumerators collected information on all persons, dwelling units and other structures in their EAs.

<sup>e</sup> MDHS, 2010. NSO, Malawi and ICF Macro. The 2004 MDHS survey was designed to provide estimates of health and demographic indicators at the national and regional levels, for rural and urban areas, and for selected large districts that were oversampled. To meet this objective, 522 clusters were drawn from the 1998 census sample frame: 458 in rural areas and 64 in urban areas. The following districts were oversampled in the 2004 MDHS to produce reliable district level estimates; Mulanje, Thyolo, Kasungu, Salima, Machinga, Zomba, Mangochi, Mzimba, Blantyre, and Lilongwe. The National Statistical Office staff conducted an exhaustive listing of households in each of the MDHS clusters in August and September 2004. From these lists, a systematic sample of households was drawn for a total of 15,091 households. All women aged 15-49 in the selected households were eligible for individual interview. Every third household in the 2004 MDHS sample was selected for the male survey. In these households, all men age 15-54 were eligible for individual interview.

<sup>f</sup> MICS, 2006. United Nations Children's Fund (UNICEF) and NSO, Malawi. The 2006 MICS survey was designed to provide up to date estimates at district level on a number of social development indicators, for children and women, related to the Malawi Growth and Development Strategy, the MDGs and the goals of A World Fit for Children. Specifically the survey collected information on fertility, child mortality, nutrition, child health, environment, reproductive health, education, child protection, HIV and AIDS and orphans and maternal mortality. A total of 22,994 children under the age of five, 26,259 women aged 15-49 and 7,636 men aged 15-49 were interviewed from 31,200 households in 26 districts in Malawi.

<sup>g</sup> MaiMwana Project data. Lewycka (2011). MaiMwana Project divided the district into 48 equal sized clusters each with populations of approximately 8000 people. Mchinji Boma was excluded. In 2004 enumeration teams located the central villages in each of these clusters and enumerated households as they spiralled outwards from the centre. Enumeration stopped when a population of 3000 people was reached. Within this total population of 146,623 a total of 43,719 women aged between 10 – 49 were enumerated. The data presented here comes from the 3002 women who gave birth in the 48 study clusters between January and June 2005, which comprised the 'prospective baseline' period before the women's group intervention started. MaiMwana baseline data does not provide information on key demographic variables of Mchinji District or women's group clusters as it is only collected from women aged 10 – 49 and does not include information from Mchinji Boma the administrative centre of the district. Thus it is not possible to extrapolate from this data to the whole population of the district or clusters.

<sup>h</sup> MaiMwana Project data. Lewycka (2011). MaiMwana Project divided the district into 48 equal sized clusters each with populations of approximately 8000 people. Mchinji Boma was excluded. In 2004 enumeration teams located the central villages in each of these clusters and enumerated households as they spiralled outwards from the centre. Enumeration stopped when a population of 3000 people was reached. Within this total population of 146,623 a total of 43,719 women aged between 10 – 49 were enumerated. The data presented here comes from the 1465 women who gave birth in the 24 women's group clusters between January and June 2005, which comprised the 'prospective baseline' period before the women's group intervention started. MaiMwana baseline data does not provide information on key demographic variables of Mchinji District or women's group clusters as it is only collected from women aged 10 – 49 and does not include information from Mchinji Boma the administrative centre of the district. Thus it is not possible to extrapolate from this data to the whole population of the district or clusters.

### **4.2.3 Target group**

The primary population targeted by the intervention is women of childbearing age (aged between 15 and 49) and their children living in the 24 clusters receiving the women's group intervention. On average the women in this target group were aged 23 and the majority are Chewa (84.7%) and Christian (96.0%) (Lewycka, 2011) (table 4e - page 137).

Farmers (56.8%) and students (30.5%) made up the large majority of this target group of which almost one quarter (23.2%) had received no formal education, 70.2% had received primary education as their highest level of achievement, 6.4% had received secondary education and only 0.4% had received tertiary education (Lewycka, 2011).

Most women in the target group were married (55.5%) and had previously been pregnant (58.2%) (Lewycka, 2011). The characteristics of these women in relation to: ANC; facility delivery; and PNC within 42 days are presented above (last column of table 4d - page 134 to 135).

*Table 4e: Key socio-economic and demographic characteristics of women of childbearing age in women's group clusters*

		<b>Targeted<sup>a</sup></b>
		n = 24,175
<b>Age</b> <i>mean</i>		<b>23.34</b>
<b>Tribe</b> <i>percentage</i>	Chewa	<b>84.7</b>
	Ngoni	<b>8.2</b>
	Senga	<b>3.2</b>
	Other	<b>3.8</b>
<b>Religion</b> <i>percentage</i>	Catholic	<b>42.2</b>
	Other Christian	<b>53.8</b>
	Muslim	<b>2.3</b>
	Other	<b>1.7</b>
<b>Socioeconomic quintile</b> <i>percentage</i>	1 = poorest	<b>20.5</b>
	2	<b>20.3</b>
	3	<b>19.7</b>
	4	<b>18.3</b>
	5 = least poor	<b>21.1</b>
<b>Education</b> <i>percentage</i>	None	<b>23.2</b>
	Primary	<b>70.2</b>
	Secondary	<b>6.4</b>
	Tertiary	<b>0.4</b>
<b>Occupation</b> <i>percentage</i>	Farmer	<b>56.8</b>
	Ganyu (piecework)	<b>1.2</b>
	Salaried	<b>1.2</b>
	Business	<b>4.4</b>
	Student	<b>30.5</b>
	No work	<b>5.9</b>
<b>Marital status</b> <i>percentage</i>	Married	<b>55.5</b>
	Never married	<b>37.9</b>
	Divorced	<b>4.3</b>
	Widowed	<b>1.8</b>
<b>Parity</b> <i>percentage</i>	Ever pregnant	<b>58.2</b>
	Never pregnant	<b>41.8</b>
<sup>a</sup> <b>MaiMwana Project data.</b> Lewycka (2011). MaiMwana Project divided the district into 48 equal sized clusters each with populations of approximately 8000 people. Mchinji Boma was excluded. In 2004 enumeration teams located the central villages in each of these clusters and enumerated households as they spiraled outwards from the centre. Enumeration stopped when a population of 3000 people was reached. Within this total population of 146,623 a total of 43,719 women aged between 10 – 49 were enumerated. The data presented here comes from the 24,175 women aged between 10 and 49 who were enumerated in the 24 women's group clusters by the end of the 'baseline' period (end of 2004).		

Additional pregnancy care and care seeking indicators include: 11.7% had received voluntary counseling and testing (VCT) during ANC; and 42.6% had slept under an ITN the previous night (Lewycka, 2011) (table 4f - page 139). Regarding additional birth care and care seeking indicators: about one-third (36.0%) gave birth with a skilled provider; and 41.2% gave birth with a TBA (Lewycka, 2011). Finally, regarding additional PNC and care seeking indicators: almost all (93.3%) wrapped their baby within 30 minutes of birth; just under one-third (31.5%) bathed their baby after 24 hours; and three quarters (77.5%) initiated breastfeeding within one hour (Lewycka, 2011).

The target group also included all other women and girls below 15 and over 49 years as a secondary target population. Finally, from the end of Phase 2 of the cycle all other community members were also targeted as a tertiary target population. Data on characteristics of secondary and tertiary target groups is not available.

Table 4f: Key care and care seeking indicators of women or childbearing age in women's group clusters

	Targeted <sup>a</sup>
	n = 24,175
<b>Any VCT during ANC</b> <i>percentage</i>	<b>11.7</b>
<b>Slept under ITN last night</b> <i>percentage</i>	<b>42.6</b>
<b>Birth with a skilled provider</b> <i>percentage</i>	<b>36.0</b>
<b>Birth with a TBA</b> <i>percentage</i>	<b>41.2</b>
<b>Wrapped baby within 30 minutes</b> <i>percentage</i>	<b>93.3</b>
<b>Bathed baby after 24 hours</b> <i>percentage</i>	<b>31.5</b>
<b>Initiated breastfeeding within one hour</b> <i>percentage</i>	<b>77.5</b>
<sup>a</sup> <b>MaiMwana Project data.</b> Lewycka (2011). MaiMwana Project divided the district into 48 equal sized clusters each with populations of approximately 8000 people. Mchinji Boma was excluded. In 2004 enumeration teams located the central villages in each of these clusters and enumerated households as they spiraled outwards from the centre. Enumeration stopped when a population of 3000 people was reached. Within this total population of 146,623 a total of 43,719 women aged between 10 – 49 were enumerated. The data presented here comes from the 24,175 women aged between 10 and 49 who were enumerated in the 24 women's group clusters by the end of the 'baseline' period (end of 2004).	

#### **4.2.4 Objectives / methods**

To achieve its aims the women's group intervention consists of the following components: groups; members; a cycle of meetings; PRA tools; picture cards; facilitators; and supervisors.

##### **Groups**

From May 2005 women's groups were established within villages in women's group clusters. An individual village could choose to have its own group, more than one village could choose to meet in the same group (particularly if the villages were quite small and geographically close) or a village could choose to have more than one group (particularly if the village was large). All villages in each of the 24 clusters were offered the opportunity to access the intervention and groups were established with villages that expressed an interest to be involved. After formation the groups were supported, where necessary, to make decisions about further configuration. In this way some groups chose to disband, others chose to join with nearby groups and still others became 'dormant' before they finished the first cycle.

##### **Members**

The exact number and criteria for membership of groups, in age, marital status, etc, were decided by the group members themselves. However, in Phase 1 and 2 of the cycle the groups had a membership restricted to only women and girls. Men did attend two meetings in these phases but were not involved in decision-making until Phase 3 and 4.

##### **MaiMwana women's group cycle**

Each group was supported through a community mobilisation action cycle. The MaiMwana women's group cycle is based on the women's group model initially developed by Warmi in Bolivia (Howard-Grabman and Snetro, 2003) and subsequently implemented by MIRA in Makwanpur, Nepal (Morrison et al, 2005). Similar models are being implemented by: MIRA in Dhanusha in Nepal; SNEHA in Mumbai and Ekjut in Jharkhand and Orissa in India; MaiKhanda Project in Lilongwe, Salima and Kasungu and The Perinatal Care Project in Ntcheu in Malawi; and PCP in Bogra, Faridpur and Moulavibazar in Bangladesh. The cycle consists of four phases and 20 meetings (figure 4g - page 143):

##### *Phase 1: Identifying and prioritising problems together (eight meetings).*

Before phase 1, community entry meetings were conducted to inform communities of the women's group intervention, including its aims, objectives and principles, receive consent from community members to establish groups and recruit community members to participate in the groups. Subsequently, communities formed groups (meeting 1) a process that included electing committee members and developing constitutions. Then the group members worked together to identify all the maternal (meeting 2) and child (meeting 3) health problems affecting women and children. They also consulted the rest of the community about the problems they felt



existed in the community (meeting 4). Equipped with lists of health problems the groups, using their own criteria, then prioritised the five they felt were most important (meeting 5) and that they wanted to address first. The groups were encouraged to split these problems so that at least two or three were maternal problems and the others were child problems. The groups then spent the next two meetings exploring these five priority problems and identifying the factors that contributed to them (meeting 6) and the activities that could be implemented to prevent and manage them (meeting 7). Furnished with this information the women's group members convened a meeting with men (meeting 8) to present everything they have discussed in the previous seven meetings, explain what they were hoping to do in the future, gather the opinions and ideas of men, answer any questions they had and encourage their participation in the groups.

*Phase 2: Planning solutions to problems together (four meetings).*

The group members began this phase by working together to create a list of strategies to address the five problems they had prioritised (meeting 9). In meeting 10 the groups critically explored these strategies by considering the resources available locally that could facilitate and the barriers that could hinder their implementation (meeting 10). In this way the groups identified a final list of strategies that they considered feasible and made best use of resources available locally. In meeting 11 the groups prepared a presentation about everything they had done from meeting 1 to 10. The groups then invited all community members and presented this information and explained what they hoped to do in the future, gathered opinions and ideas of the community as a whole, garnered pledges of support, answered questions and encouraged participation in the groups (meeting 12).

*Phase 3: Implementing solutions together (four meetings).*

In this phase the groups progressed through four steps with each strategy. The groups had the choice to implement all the strategies at one time or to implement them sequentially and to work together or to split into committees responsible for each strategy. These decisions were made in the first step where the groups planned the strategies including identifying necessary activities, who would be responsible for these, necessary resources and a timeline for implementation (meeting 13). In the next step the group gathered all the resources and assets needed (meeting 14). In the third step the groups developed a plan and tools for monitoring the strategies (meeting 15). Finally, in step four, the groups put the strategies into operation (meeting 16).

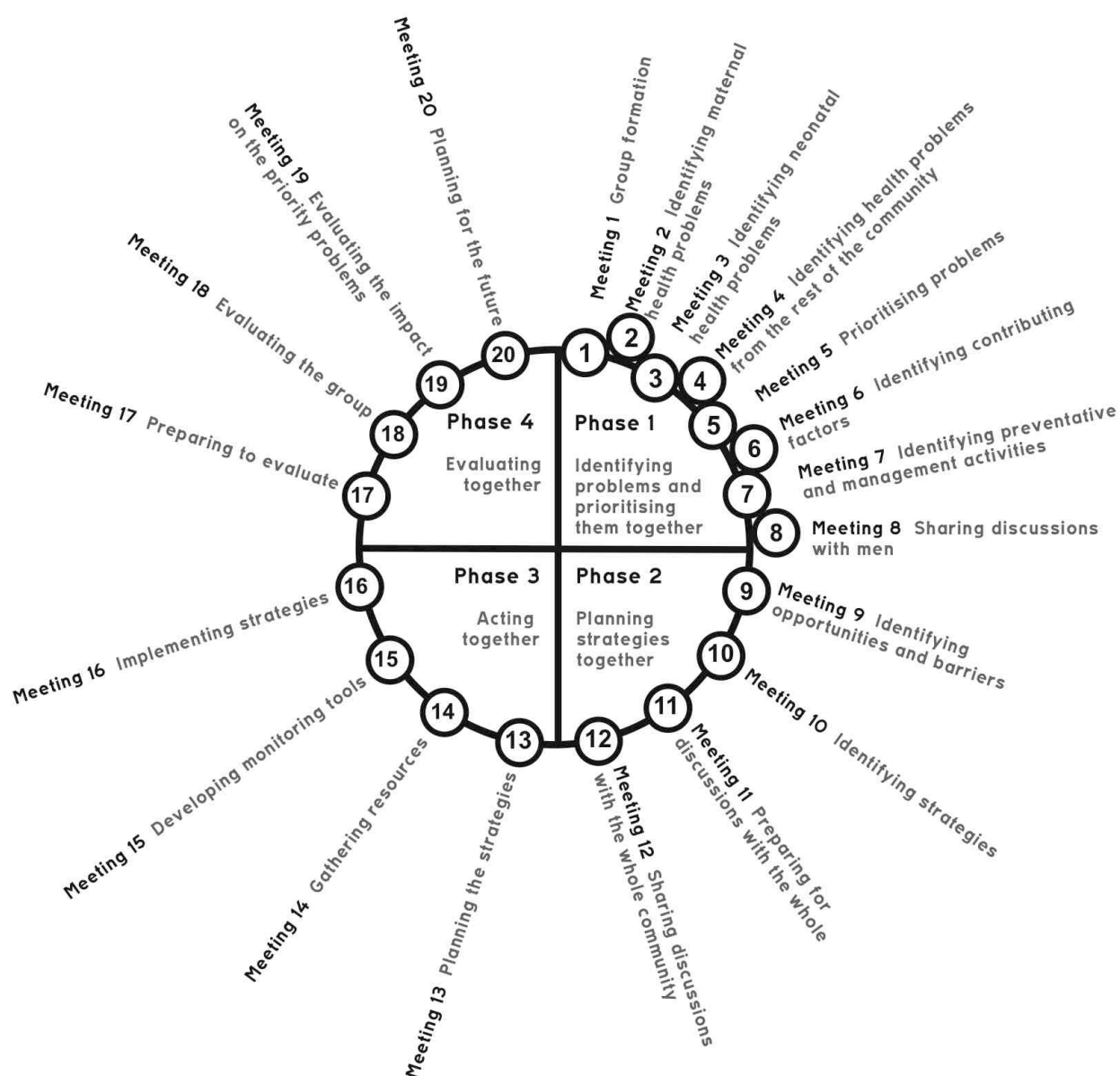
*Phase 4: Evaluating together (four meetings).*

In the first meeting of this phase the groups discussed what evaluation is and why it is important (meeting 17). The groups proceeded to engage in an evaluation of the operation of the groups identifying actions they could take to improve them in the future (meeting 18). In the next meeting the groups went through a similar evaluation process but focussed on the

operation of the strategies and what actions could be taken to improve them (meeting 19). In the last meeting of the cycle the groups reviewed the results of their evaluations and planned their actions to improve the groups and strategies (meeting 20). In this meeting the groups also decided what the next cycle of the intervention would look like: whether the group would continue to meet or would disband; whether the cycle would involve identification of new problems (requiring the group to start the next cycle at phase 1) or continued work on the same problems; whether the cycle would involve identification of new strategies (requiring the group to start the next cycle at phase 2) or continued implementation of existing strategies (requiring the group to start the cycle at phase 3).

In parallel to the women's group cycle regular 'sensitisation' meetings were also carried out by MaiMwana Project staff at the local, area and district levels to inform and encourage support from individual, group and organisational stakeholders and partners.

Figure 4g: The MaiMwana women's group intervention cycle



## Tools

Discussion in the MaiMwana women's group cycle was facilitated and stimulated by three types of tools: women's group manuals; PRA tools; and picture cards.

### *Manuals*

The women's group manuals were guidelines for implementation of the four phases and 20 meetings. MaiMwana Project developed three manuals: one for Phase 1 and 2; one for Phase 3; and one for Phase 4. The first section of all the manuals was a brief introduction to the project, the cycle and the relevant phase(s) of the cycle. The next section detailed guide for each meeting in the phase(s). These meeting guides outlined: the aims and objectives of the meetings; what needed to be prepared before the meetings; discussion prompts related to the aims and objectives of the meetings; what PRA tools or picture cards could be used to facilitate and stimulate these discussions; and what needed to be done after the meeting. The third section of the manuals consisted of a number of PRA tools that could help to facilitate and stimulate discussion in the meetings covered by the manual. The final section was examples of a number of meeting monitoring forms that could be filled in to record what had been achieved during the meetings.

### *Participatory rural appraisal tools*

A choice of PRA tools was provided to groups to help facilitate and stimulate their discussions:

- Identification of problems (Phase 1): body mapping (the group draws a woman or a child and indicates where on their bodies they might be afflicted by problems at different stages of pregnancy, delivery or after birth); timeline (the group draws a timeline for a woman or a child, indicates different stages of pregnancy, delivery or after birth and indicates the problems that might afflict them at these different stages); stories (the group reads out a story of a woman or child who experienced some health problems and then discusses what other problems they might experience)
- Prioritisation of problems (Phase 1): preference ranking (blind ranking with each group member voting for the problem they feel is most important); pairwise ranking (the group systematically compares each problem to every other problem); diamond ranking (the group sorts the problems into an order of importance)
- Identification of contributing factors (Phase 1): cause-effect diagram (the group assesses each problem in terms of input arrows (causes) and output arrows (effects)); problem tree (the group assesses each problem (tree trunk) in terms of its inputs (roots) and outputs (branches and leaves); but why? (the group assesses each problem by asking but why did it arise until the root contributing factors are identified)
- Identification of solutions, resources and barriers (Phase 2): H-exercise; bridge the gap; balloon (all three of these tools are different visualizations of the same process which involves discussing the present situation, hopes for the future and how it can be reached)
- Evaluating groups and strategies (Phase 4): spider diagram; graph

### *Picture cards*

Besides the PRA tools, picture cards were also used to facilitate and stimulate discussion particularly in Phases 1 and 2:

- Problem cards (21 cards): these cards covered the main health problems affecting mothers and children in Malawi.
- Contributing factor cards (17 cards): these cards covered the main contributing factors to problems affecting mothers and children in Malawi.
- Preventative activity cards (13 cards): these cards covered the main activities people could perform to prevent problems affecting mothers and children from arising.
- Management activity cards (9 cards): these cards covered the main activities people could perform to manage problems affecting mothers and children once they had already arisen.

The cards had a number of functions. When the groups were identifying problems, contributing factors, preventative and management activities the cards were used to clarify what was being discussed and to stimulate further discussion. When discussing contributing factors, preventative and management activities the cards were arranged and problems were linked to their associated contributing factors, preventative and management activities. In this case the cards stimulated further discussion about the relationship between the problem and these other factors. When the groups were looking at potential solutions the cards could be arranged as a summary of a particular problem and its associated contributing factors, preventative and management activities as a basis for discussion about what could be done to address the situation. Finally, when the groups were presenting their discussions to others they could be used to illustrate what they had discussed and how things were related. The cards were generally employed after the issue depicted on the card had already been identified to allow for further discussion. They were not used to prompt groups to identify certain things (Rosato et al, 2006).

## **Staff**

### *Facilitators*

In each of the 24 women's group clusters one facilitator was recruited in October 2004. Positions for Zonal Facilitators (ZFs) were advertised and applicants shortlisted and invited to interview. Essential requirements for ZFs were: coming from within a women's group cluster; being similar to others in socio-economic status and other demographic characteristics; being literate in Chichewa and having at least a Junior Certificate of Education; having at least one child; and being aged between 20 and 49. Having previous experience of working in community development was considered desirable.

The ZFs received an initial 11-day residential training in November 2004. The training covered an introduction to MaiMwana Project and the women's group cycle, facilitation skills, meetings, methods and tools, picture cards, monitoring forms and the supervision system. The ZFs began implementing the intervention in women's group communities in May 2005 after a period of practice.

The ZFs also attended further 5-day residential 'refresher' trainings approximately every four months. These trainings covered general topics such as facilitation skills, communication skills and leadership skills and were also reactive to the needs expressed by the ZFs or that arose through observation and supervision of women's group meetings. The ZFs received only basic training in issues relating to MCH including information about the main MCH problems affecting women and children in Malawi and the symptoms and main factors causing them.

The ZFs formed and facilitated groups to mobilise their communities to improve mother and child mortality and morbidity. They used the manuals, PRA tools and picture cards to form groups and guide them through the MaiMwana women's group action cycle. They monitored this process by filling in monitoring forms after each meeting recording what had been achieved. In Phase 2 and 3 they also trained group members, group leaders and group committees in necessary skills, advocated for the groups at the local level and liaised with community level stakeholders and partners.

In the second cycle of the intervention three volunteers (two female and one male) from each group were elected by group members to become Volunteer Facilitators (VFs). These VFs were trained and took over the facilitation of the groups and other responsibilities from the ZFs who became their primary supervisors. The ZFs met the VFs monthly to discuss progress, identify and resolve challenges and provide training.

#### *Supervisors and senior supervisor*

Four facilitation and training officers (FTOs) and one senior facilitation and training officer (SFTO) were recruited in September 2004. They had extensive experience of working with communities. Due to the geographical spread of the women's group clusters across the district it was not possible for the FTOs to be based at one central point. As a result, the district was divided into four nodal areas. Each nodal area covered six women's group clusters and between 10 and 13 clusters in total. An office was established at a central point in each of these nodal areas (Kamwendo, Kapiri, Mkanda and Waliranji) where the four FTOs were posted to live and work. The SFTO was based at the project head office in Mchinji Boma.

The FTOs oversaw the work of the six ZFs and associated groups in their nodal area. They visited each ZF approximately twice per month to observe the meetings being conducted, feedback constructive criticism and address any problems. They also held monthly meetings at

their nodal office, attended by all six ZFs in their nodal area, to share achievements and challenges, identify potential strategies to address these challenges and collect monitoring forms and reports. The FTOs recorded their supervisory visits and monthly meetings in reports that were handed on to the SFTO at a monthly meeting at the head office attended by all four FTOs.

The supervisors and senior supervisor also trained the ZFs in facilitation and community mobilisation and to use the manual, PRA tools, picture cards and monitoring forms. This training was conducted on an ad-hoc basis during supervisory visits and monthly meetings and formally at the residential ‘refresher’ trainings.

#### **4.2.5 Resources**

The most significant resource inputs for the women’s group intervention were the ZFs and supervisors employed to run the intervention. These members of staff received a salary and equipment and materials to conduct their work:

- ZFs received a salary of approximately £40 per month, a bicycle, a T-shirt, an umbrella, a field bag, a copy of the women’s group manuals, a set of picture cards, stationery and adequate numbers of printed monitoring forms.
- Supervisors received a salary of between £200 to £350 per month, the shared use of a motorcycle, riding equipment, a T-shirt, fuel, stationery and adequate numbers of printed monitoring forms.

Other major inputs included residential training sessions for all ZFs and supervisors approximately every four months, office rent for the head office and nodal offices and capital equipment expenditure for computers, furniture and other office equipment.

### **4.3 Methodology**

Some academics have claimed it is beneficial to mix the different approaches to grounded theory as this allows researchers to learn new ways of working with the methodology and avoid the belief that there is only one way to use it (Morse and Richards, 2002). However, these approaches differ on a much deeper level than the methodological level. They differ on a philosophical and ideological level and thus mixing Glaserian and Straussian approaches should be done with caution as this may violate their philosophical underpinnings. As a result, other academics have advised a maintaining the boundaries between them rather than attempting any synthesis (Heath and Cowley, 2004).

The original version of grounded theory was selected as the methodology to guide this thesis. With the conflicts inherent in the method in mind a middle ground between induction and deduction was attempted by paying attention to extant theory in the area under investigation

but also remaining reflexive and always reminding myself that I am human and what I observe is a function of who I am and what I hope to achieve (Suddaby, 2006). Thus, reading deeply into Glaserian and Straussian grounded theory was not used to develop a synthesis of these methods but rather to more deeply understand the conflicts inherent in the original method and draw out guidelines for how to balance its contradictory inductive and deductive nature – how to be both objective and creative – which are lacking in the original grounded theory text.

Original grounded theory was selected as the methodology for this thesis because it can help to generate theory, understand process, understand people's experiences, and conduct good science.

The aim of this thesis is to develop a theory to explain how community mobilisation addresses the SDH. This requires surfacing the underlying mechanisms through which it works and these are implicit, complex, relatively unknown and unrecognised. Grounded theory has the potential to enlighten the procedures, actions and interactions that comprise these mechanisms and thus to generate a new substantive theory as no theory currently exist (Stern, 1994). In this way it is particularly suited to the exploration of areas such as the mechanisms of community mobilisation that have been relatively overlooked and have received only superficial attention and where ones 'off the shelf' are not available (Samik-Ibrahim, 2000; Creswell, 2009). Using a grounded theory methodology will ensure that the theory developed will work, will be relevant, will fit, and will be modifiable; characteristics that ensure that the theories have high explanatory power.

Grounded theory's quest to study basic social processes means it is particularly suited to understanding processes and the connections between events (Charmaz, 2000). The mechanism through which the MaiMwana women's group intervention addresses the SDH can be conceptualised as a set of processes through which individuals, organisations and groups take control over their lives.

Community mobilisation approaches operate on the level of the community, group / organisation and the individual. Indeed, the ultimate question under investigation in this thesis is how is mortality reduced through the process of community members attending women's groups. These reductions result from changes in human behaviour, which in turn are the result of complex internal factors. As a result, the underlying mechanisms of the intervention can be best understood by drawing categories from the respondents themselves thus making these implicit belief systems explicit (Moghaddam, 2006). By paying attention to people's interpretations of what is going on it is possible to get access to the underlying reality. Grounded theory supports this process by seeking to understanding the voice and experiences of participants in as rigorous and detailed a manner as possible (Denzin and Lincoln, 2000).



Finally, performed well grounded theory can meet all the requirements of ‘good science’ – significance; theory observation; comparability; generalisability; reproducibility; precision; rigour; and verification (Strauss and Corbin, 1998). Indeed grounded theory was specifically developed to assist qualitative researchers to carry out good science by providing codified and clear methods for collecting, assembling and presenting qualitative information (Goede and Villiers, 2003). The approach helps to systematize the process of theorising and supports the development of theories that are ‘thick’, have a clear purpose and are well integrated without curbing the creativity necessary for theory generation (Glaser and Strauss, 1967).

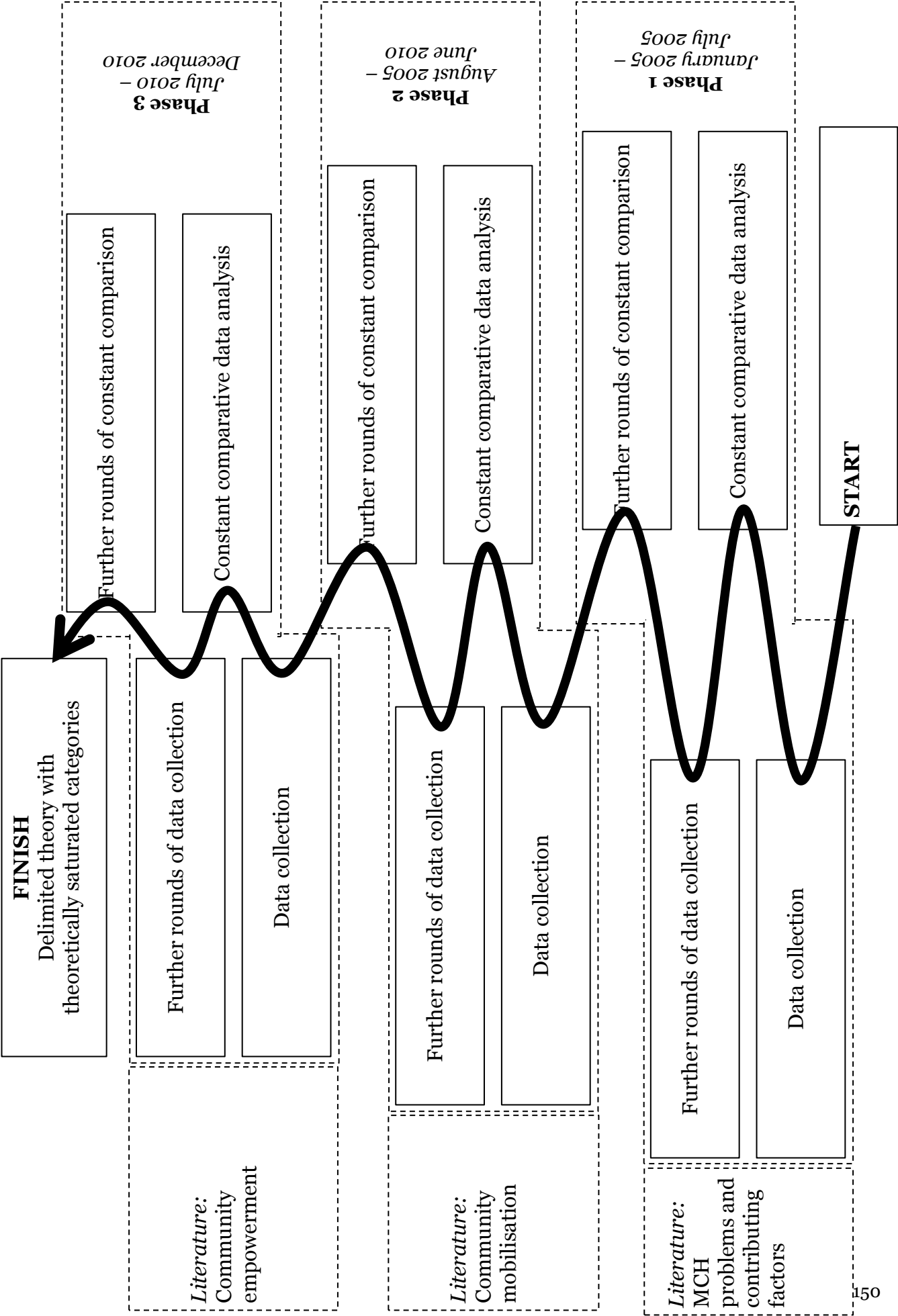
#### **4.4 Research design**

To ensure that the grounded theory methodology used in this thesis does not ignore or violate the core procedures and tenets of the approach, how it was used in practice will be described here (Locke, 1996; Suddaby, 2006).

Grounded theory does not lend itself easily to presentation in the traditional categories and sequence of quantitative research. In its pure form grounded theory would be presented as a jumble of literature consultation, data collection and analysis conducted in ongoing iterations that produce many relatively fuzzy categories that over time reduce to fewer, clearer conceptual structures and eventually presentation of the theory (Suddaby, 2006). Obviously, presenting a thesis in this manner would not be efficient, comprehensible or permitted. As a result, this thesis has been presented according to a traditional framework with theory being presented first, followed by data analysis, results and discussion. However, although theoretical concepts have been presented at the beginning of this thesis (chapters 1, 2 and 3), these concepts did not constitute a priori hypotheses that were subsequently tested. In truth these theoretical concepts were distilled through an iterative cycle combining data collection and analysis and reading of relevant literature indicated by the results of the data analysis.

This thesis was conducted in three overlapping phases of data collection, analysis and literature review between January 2005 and December 2010 (figure 4h - page 150). This period comprised at least one full cycle of the intervention for the 197 MaiMwana women’s groups that were still active. The three phases of the thesis can be thought of as spiraling inwards or drilling down. They started in a relatively unstructured manner asking broad questions in a wide variety of settings. Gradually, the emergent categories and theory, merged with relevant literature, drove the development of the methods to ask more structured and specific questions although still in a wide variety of settings. The final phase of this process developed methods that were even more delimited asking specific questions in a more confined range of settings. Thus, these three phases or cycles of data collection and analysis helped to enhance theoretical sensitivity to critical issues and thus emerge the theory (Heath and Cowley, 2004).

Figure 4h: Phases of the thesis



The theory that emerged, rooted in the iterative data collection, analysis and literature review cycles in the three phases, identified operational components of the empowerment mechanism (which as they emerged were defined by the literature reviewed in chapter 3 as operational domains) and their principles of operation (which as they emerged were defined by the literature reviewed in chapter 3 as intervention activities and immediate, intermediate and long-term outcomes). Towards the end of the thesis, as the theory started to delimit, it was compared against all the existing theories presented in chapter 3 and found to resonate most closely with Laverack's (1999) nine domains model. Comparisons found it echoed the components of the other models either less well or only partially.

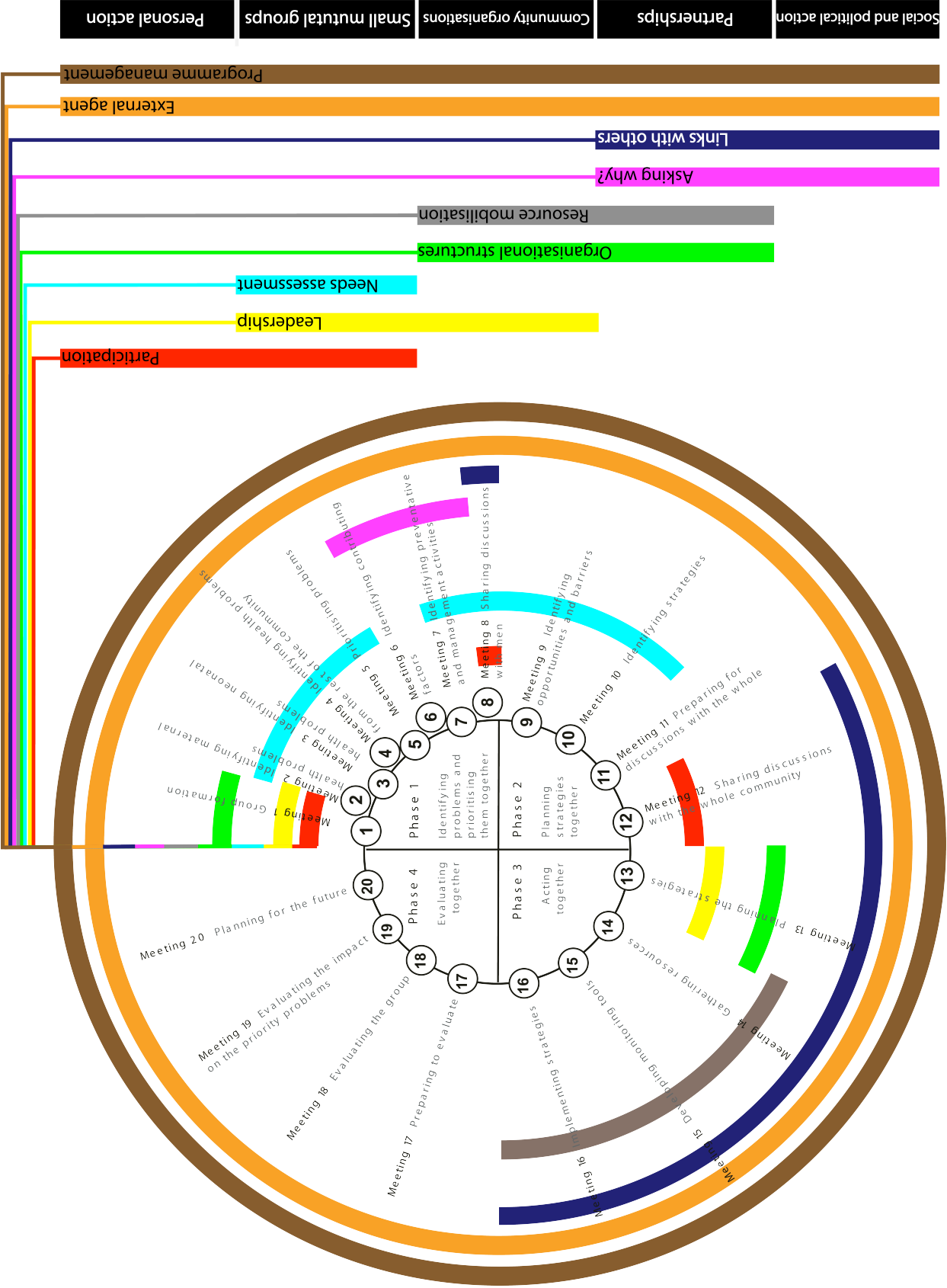
The operational factors of community empowerment represent those factors that help individuals, organisations and communities to become ever more organised and mobilised. As a result, they enable individuals, groups and communities to progress along the community empowerment continuum from psychological empowerment to collective social and political action. In doing this they enable individuals, groups and communities to harness the interpersonal elements that arise out of the community empowerment process - to harness the benefits of organisation - and bring them to bear on the broader social determinants of their health. These operational factors can be acted upon directly by community empowerment programmes to achieve their objectives (Rifkin, 1990). To be effective, any community mobilisation programme concerned with empowering communities to address the broader determinants of health needs to promote these factors in the communities in which it is working. If they exist then a community can be considered capable or empowered and thus better able to exercise control over the social determinants of MCH. If they are absent then a community is not empowered and is unable to exercise control over the social determinants of MCH. Thus, logically, the operational factors represent the qualities of an empowered community and can provide a means of understanding the way in which community empowerment programmes start with individuals, progress through a group process and ultimately have an influence on the broader determinants of health. Describing the activities provided by the intervention and exploring the immediate, intermediate and long-term outcomes of these operational factors will thus help to surface the sequences of linked activated entities - the socio-environmental mechanism - that explain how communities become empowered to address the SDH.

Furthermore, the nine domains can also be clearly distinguished in the design of the meetings and phases of the MaiMwana Project women's group cycle (figure 4i - page 153). All the domains are promoted throughout the women's group cycle both during and between meetings and they are particularly evident in specific meetings. Participation is particularly evident in meeting 1 (when new groups are formed), meeting 8 (when men are invited to participate) and meeting 12 (when the whole community is invited to participate). Leadership is particularly evident in meeting 1 (when group committee members are elected) and meeting 13 (when

strategy task force members are elected). Needs assessment is particularly evident in meeting 2 to 5 (when maternal and neonatal problems are identified and prioritised) and meeting 7 to 10 (when men's perceptions of problems are requested and preventative and management activities and strategies to address problems are identified). Organisational structures are particularly evident in meeting 1 (when group committees are formed and constitutions developed) and meeting 13 (when strategy committees are formed and constitutions developed). Resource mobilisation is particularly evident in meeting 14 to 16 (when groups mobilise resources to implement their strategies). Asking why is particularly evident in meeting 6 and 7 (when groups identify factors that contribute to their maternal and neonatal health problems and ways to prevent these contributing factors from arising and manage problems if they arise). Links with others are particularly evident in meeting 8 (when the groups engage with men in the community) and meeting 12 to 16 (when the groups engage with the whole community and with other individuals and organisations within and outside their community). The last two domains, role of external agents and community involvement in programme management are specific to the development of community empowerment in a programme context. As a result, they are not specific to any one meeting. Instead they are constantly negotiated throughout the entire women's group cycle.

It is understood that the nine domains model is not the 'true' or 'best practice' model as any model is contingent: one size will not fit all communities (Hawe et al, 2000). However, evidence from field trials supports this model and suggests that it is the most robust, theoretical and face valid and succinct of the different models available (Labonte and Laverack, 2001). Furthermore, although there is no definitive set of characteristics to describe an empowered community, such capabilities do not vary infinitely between communities or situations (Labonte and Laverack, 2001). As a result, to prevent proliferation of models and terms, and to allow maximum comparability to existing studies, the nine domains model headings were adopted as a template to present, in chapters 5, 6 and 7, the findings - the sequences of linked activated entities of the socio-environmental mechanism that explain how the communities improve MCH and reduce mortality.

Figure 4i: Presence of the nine operational domains in MaiMwana Project women’s group meetings and their relationship to stages of the community empowerment continuum



#### **4.4.1 Phase 1 - January to June 2005**

In this phase the specific objectives for the thesis had not been defined. Instead, it was guided by the basic aspiration to investigate 'how MaiMwana women's groups work'. Glaser and Strauss (1967) support this approach by encouraging researchers to start gathering data to formulate ongoing plans and discover the nature of the research questions rather than formulating them from the literature before data collection.

#### **Literature**

The review explored the MCH literature and, in particular, the main problems affecting these groups and their contributing factors. As stated by Glaser and Strauss (1967) carrying out such an exploratory review allowed the development of a partial framework of local concepts, designating a few principal or gross features of the structure and processes in the area being studied. This review is presented in chapter 1.

#### **Data collection methods**

Data was collected through 31 unstructured observations (table 4j - page 155). Participant observation was conducted of ZF training sessions, women's group team nodal and head office meetings and quarterly ZF training sessions. Non-participant observation was conducted of women's group meetings. These observations of women's group meetings were conducted by the principal researcher (MR) in vivo (directly observed as they were conducted) but a number were also video recorded and observed later, extra vivo. All observations were concerned with collecting information about how the women's groups might be addressing MCH issues.

Informal conversations and interactions were also carried out with supervisors, ZFs and community members when the opportunity arose. All observations and conversations were recorded in detail in field notebooks in textual form and as maps and diagrams.

Table 4j: Unstructured observations conducted between January 2005 and July 2005

	Participant	Non-participant		Totals
		<i>In vivo</i>	<i>Extra vivo</i>	
Women's group meetings	-	1	5	6
Team nodal meetings <sup>a</sup>	20	-	-	20
Team head office meetings <sup>b</sup>	4	-	-	4
ZF training sessions <sup>c</sup>	1	-	-	1
<b>Totals</b>	<b>25</b>	<b>1</b>	<b>5</b>	<b>31</b>
<sup>a</sup> Monthly meetings conducted at nodal offices between the FTO, the 6 ZFs in the nodal area, in the presence of the SFTO. <sup>b</sup> Monthly meetings conducted at the head office between the SFTO and 4 FTOs. <sup>c</sup> Refresher and specific training sessions carried out with the 24 ZFs and conducted by MaiMwana staff and representatives from other organisations.				

### **Sampling methods and sample**

Glaser and Strauss (1967) stated that theoretical sampling does not require the fullest possible coverage on the whole group except at the beginning of research, when the main categories are emerging. Therefore, during this phase purposive sampling was conducted to ensure as wide and diverse a theoretical sample as possible to provide the maximum range of information for initiating the development of the theory. As a result, all ZF training sessions, team nodal meetings and head office meetings that took place during this period were observed. In addition, purposive maximum variation sampling was employed to select women's groups for observation. This involved developing a sample with a wide variation on key dimensions theorised to influence how the groups might be working. In this case the dimensions were nodal office, cluster, group and meeting. As a result, six different groups, from five different clusters, all four different nodal offices and engaging in three different meetings were observed (table 4k - page 157; and 4l - page 158).



*Table 4k: Details of unstructured observations carried out with women's groups between January 2005 and July 2005*

<b>Nodal office</b>		<b>Cluster</b>		<b>Group</b>	
Name	Number of observations	ID	Number of observations	ID	Number of observations
Kamwendo	<b>2</b>	15	<b>2</b>	1501 1503	<b>1</b> <b>1</b>
Kapiri	<b>1</b>	33	<b>1</b>	3308	<b>1</b>
Mkanda	<b>2</b>	37	<b>1</b>	3702	<b>1</b>
		42	<b>1</b>	4207	<b>1</b>
Waliranjji	<b>1</b>	24	<b>1</b>	2407	<b>1</b>

*Table 41: Details of unstructured observations carried out with women's groups between January 2005 and July 2005*

<b>Phase</b>	<b>Meeting</b>	<b>Number of observations</b>
<b>1</b>	<b>1</b>	<b>1</b>
	<b>2</b>	<b>2</b>
	<b>3</b>	<b>3</b>
<b>Total</b>		<b>6</b>

#### **4.4.2 Phase 2 - August 2005 to June 2010**

##### **Literature**

As more data was collected and analysed the review of the literature became more focussed and built on the data and literature explored in the previous phase. In this phase the review was no longer exploratory and instead became more concerned with specific features of the mechanisms through which the MaiMwana women's group intervention might be influencing MCH and mortality. This included the physiological, behavioural and socio-environmental mechanisms. This involved a review of the community mobilisation literature which is presented in chapter 2.

##### **Data collection methods**

The participant and non-participant observation initiated in the previous phase was continued in this phase. In total 291 observations were conducted which started as unstructured observations as in the previous phase but gradually evolved into a more semi-structured approach as relevant categories were identified through analysis of the emerging data and review of the literature (table 4m - page 160). In this way the direction of further data collection and literature review was guided from the field. As a result, the semi-structured observations came to focus on collecting information about the constituent components of the mechanisms of the intervention: immediate outcomes (characteristics of the participants that change as a result of the intervention inputs), intermediate outcomes (the behaviour changes that follow the immediate changes in knowledge, awareness, skills, opportunities and attitudes) and long-term outcomes (global changes and community impacts as a result of the intermediate behaviour changes). A semi-structured list of areas for observation was developed from these components and continually refined using new data and literature (appendix 2). These semi-structured observations were conducted by MR in vivo and extra vivo, using the list of areas for observation, during ZF training sessions, team nodal meetings, team head office meetings, women's group meetings, management meetings, directors meetings and other meetings.

Informal conversations and interactions were also carried out with supervisors, ZFs and community members when the opportunity arose. All observations and conversations were recorded in detail in field notebooks in textual form and as maps and diagrams.

Besides the primary qualitative data, secondary information such as intervention documents was also reviewed. Of particular use were the monthly reports written by the ZFs, supervisors and senior supervisor, which summarised progress and covered the main achievements and challenges experienced during the month.

Table 4m: Semi-structured observations conducted between August 2005 and June 2010

	Participant	Non-participant		Totals
		<i>In vivo</i>	<i>Extra vivo</i>	
Women's group meetings	-	52	24	<b>76</b>
Team nodal meetings <sup>a</sup>	66	-	-	<b>66</b>
Team head office meetings <sup>b</sup>	37	-	-	<b>37</b>
Management meetings <sup>c</sup>	49	-	-	<b>49</b>
Director's meetings <sup>d</sup>	30	-	-	<b>30</b>
ZF training sessions <sup>e</sup>	10	-	-	<b>10</b>
Other <sup>f</sup>	23	-	-	<b>23</b>
<b>Totals</b>	<b>215</b>	<b>52</b>	<b>24</b>	<b>291</b>

<sup>a</sup> Monthly meetings conducted at nodal offices between the FTO, the 6 ZFs in the nodal area, in the presence of the SFTO.

<sup>b</sup> Monthly meetings conducted at the head office between the SFTO and 4 FTOs.

<sup>c</sup> Meetings conducted at the head office, approximately monthly, and involving all senior management staff at MaiMwana Project.

<sup>d</sup> Meetings conducted at the head office or in Lilongwe, approximately monthly, and involving all senior management staff at MaiMwana Project and the Project Directors.

<sup>e</sup> Refresher and specific training sessions carried out with the 24 ZFs and conducted by MaiMwana staff and representatives from other organisations.

<sup>f</sup> Other formal meetings including: staff meetings (meeting at the head office involving all senior management staff and supervisory staff at MaiMwana Project), stakeholder meetings (meetings conducted at village level with local MaiMwana staff and local stakeholders and partners), partner meetings (meetings conducted with district level partners to MaiMwana project), handover meetings (meetings conducted at village level involving the handover of resources).

### **Sampling methods and sample**

As stated above theoretical sampling does not require the fullest possible coverage on the whole group except at the beginning of research, when the main categories are emerging (Glaser and Strauss, 1967). In phase 2 the process of category emergence was still the primary aim. As a result, sampling of meetings to be observed continued to reflect this aim and was directed by the nascent theory to further develop and extend the categories that make up that theory.

Almost all ZF training sessions, team nodal meetings, team head office meetings, management meetings, directors meetings and other meetings in this period were observed. In addition, women's groups were purposively maximum variation sampled to ensure that all the nodal offices and as many of the clusters and groups as possible were represented and that all the phases and meetings were covered. These dimensions were theorised to influence how the groups might be working. In total 41 of the 197 groups, from 22 of the 24 clusters, and all four of the nodal offices were observed. Each meeting in all four phases of the cycle was observed at least once (table 4n - page 162; and table 4o - page 163).

*Table 4n: Details of semi-structured observations carried out with women's groups between August 2005 and June 2010*

<b>Nodal office</b>		<b>Cluster</b>		<b>Group</b>	
<i>Name</i>	<i>Number of observations</i>	<i>ID</i>	<i>Number of observations</i>	<i>ID</i>	<i>Number of observations</i>
Kamwendo	<b>27</b>	01 02 15 17 20 25	<b>6</b> <b>5</b> <b>7</b> <b>2</b> <b>4</b> <b>3</b>	0102	<b>1</b>
				0104	<b>3</b>
				0106	<b>1</b>
				0107	<b>1</b>
				0202	<b>2</b>
				0206	<b>1</b>
				0207	<b>2</b>
				1501	<b>2</b>
				1505	<b>3</b>
				1507	<b>1</b>
				1508	<b>1</b>
				1701	<b>2</b>
				2005	<b>2</b>
				2007	<b>2</b>
				2501	<b>2</b>
				2503	<b>1</b>
Kapiri	<b>12</b>	28 29 33 34 36 45	<b>1</b> <b>2</b> <b>1</b> <b>2</b> <b>3</b> <b>7</b>	2801	<b>1</b>
				2905	<b>2</b>
				3307	<b>1</b>
				3403	<b>1</b>
				3408	<b>1</b>
				3603	<b>3</b>
				4503	<b>2</b>
				4506	<b>2</b>
Mkanda	<b>23</b>	37 38 40 41 42 43	<b>3</b> <b>4</b> <b>4</b> <b>4</b> <b>4</b> <b>0</b>	3708	<b>3</b>
				3809	<b>2</b>
				3811	<b>2</b>
				4002	<b>4</b>
				4102	<b>1</b>
				4103	<b>2</b>
				4107	<b>1</b>
				4202	<b>1</b>
				4206	<b>1</b>
				4208	<b>2</b>
Waliranji	<b>13</b>	09 10 11 12 23 24	<b>3</b> <b>4</b> <b>0</b> <b>1</b> <b>4</b> <b>1</b>	0901	<b>1</b>
				0905	<b>2</b>
				1003	<b>4</b>
				1202	<b>1</b>
				2301	<b>2</b>
				2401	<b>1</b>

*Table 40: Number of observations conducted per meeting between July 2005 and June 2010*

<b>Phase</b>	<b>Meeting</b>	<b>Number of observations</b>
<b>1</b>	<b>1</b>	<b>2</b>
	<b>2</b>	<b>2</b>
	<b>3</b>	<b>3</b>
	<b>4</b>	<b>4</b>
	<b>5</b>	<b>5</b>
	<b>6</b>	<b>4</b>
	<b>7</b>	<b>5</b>
	<b>8</b>	<b>4</b>
<b>2</b>	<b>9</b>	<b>5</b>
	<b>10</b>	<b>1</b>
	<b>11</b>	<b>2</b>
	<b>12</b>	<b>9</b>
<b>3</b>	<b>13</b>	<b>7</b>
	<b>14</b>	<b>2</b>
	<b>15</b>	<b>1</b>
	<b>16</b>	<b>11</b>
<b>4</b>	<b>17</b>	<b>2</b>
	<b>18</b>	<b>2</b>
	<b>19</b>	<b>2</b>
	<b>20</b>	<b>3</b>
<b>Total</b>		<b>76</b>

#### **4.4.3 Phase 3 - July to December 2010**

##### **Literature**

In the final phase of the thesis the literature regarding community empowerment was explored. This review is presented in chapter 3. This literature provided an increasingly detailed framework to guide the sampling, data collection and analysis in this phase and to structure and organise the components of the socio-environmental mechanism arising out of the analysis of data from all three phases of the thesis.

##### **Data collection methods**

Data in this phase was collected through 24 semi-structured FGDs with communities. The content of the semi-structured discussion schedules was guided by the literature reviewed in this phase and from the field through the findings emerging from the previous phases of the thesis. As a result, nine different schedules were developed (appendix 3) each covering a different community empowerment domain and seeking to structure the socio-environmental mechanism of the intervention in terms of its immediate, intermediate and long-term outcomes. The schedules went through several cycles of development, translation into Chichewa, piloting, review and redevelopment before they were finalised. In each of these cycles the schedules were also back translated to ensure grammatical and syntactical equivalence between Chichewa and English. MR collaborated with two research assistants (CK and NM) to develop the schedules.

CK and NM were trained to conduct the FGDs. In each of the discussions one of the facilitators acted as the moderator while the other observed and recorded all observations and related informal conversations and interactions in textual form. Each of the research assistants moderated at least one of the FGDs using each of the nine schedules.

##### **Sampling methods and sample**

In this phase theory delimitation was the primary aim and this was reflected in the sampling strategy employed. Purposive intensity sampling was used to select communities for FGDs. This form of sampling selects information-rich cases that manifest the phenomenon of interest intensely, but not extremely (Patton, 1990).

The cases were identified by MR in collaboration with the 24 ZFs, four FTOs and one SFTO. After detailed discussion of the definitions of each of the nine community empowerment domains a list of the communities that they felt expressed good and poor characteristics on each of the domains was identified. From this list, through further discussion, the communities considered to express good characteristics on each domain were ranked in order and this was repeated for the communities considered to express poor characteristics on each domain.



This process generated 18 pools of potential respondent groups; nine pools of communities considered to express good characteristics on each domain and nine pools of communities considered to express poor characteristics on each domain. Data collection continued by conducting FGDs with members of the top ranked community in the 'good pool' and 'poor pool' for each domain. These cases were selected because by expressing particularly good of particularly poor characteristics on a domain they were expected to help to elaborate and deepen the theory emerging from phases 1 and 2. They could help to achieve this by testing, verifying or refining the theory or by disqualifying some themes or strengthening others by setting boundaries and providing divergent and alternative interpretations.

Depending on the needs to delimit the emergent theory further communities were selected as respondents in rank order and from either the 'good' and/or 'poor' pools for each domain until theoretical saturation of categories was considered to have been reached and a delimited theory developed (table 4p - page 166). Once a community had been consulted on a domain it was excluded from further rounds of sampling even if it appeared in the 'good' or 'poor' pools for another domain.

Table 4p: Semi-structured FGDs conducted between July 2010 and December 2010

Schedule	FGDs	Nodal	Zone	Group	Good / poor pool
Participation	3	Kapiri	29	2905	Good
		Mkanda	41	4104	Poor
		Waliranji	09	0903	Poor
Leadership	2	Kamwendo	17	1701	Good
		Waliranji	10	1006	Poor
Organisational structures	4	Kamwendo	02	0206	Good
		Kapiri	45	4505	Good
		Waliranji	23	2301	Good
		Kamwendo	25	2508	Poor
		Mkanda	38	3802	Good
Needs assessment	2	Waliranji	23	2304	Poor
		Kapiri	36	3603	Good
Asking why?	3	Mkanda	37	3703	Poor
		Kapiri	34	3404	Poor
		Kamwendo	15	1506	Good
Resource mobilisation	3	Kapiri	33	3302	Poor
		Kamwendo	01	0107	Poor
		Waliranji	11	1102	Good
Links with others	3	Kamwendo	25	2505	Poor
		Mkanda	42	4205	Good
		Kapiri	29	2902	Good
External agent	3	Kamwendo	02	0205	Poor
		Kapiri	45	4507	Poor
		Waliranji	24	2403	Good
Programme management	3	Waliranji	12	1205	Poor
		Kamwendo	25	2506	Poor
		Kamwendo = 8 Kapiri = 7 Mkanda = 4 Waliranji = 7	NA	NA	Good = 12 Poor = 14
<b>Total</b>	<b>26</b>				

Community members who took part in the FGDs were selected by the women's group chairperson in that community as they knew the communities well. The chairpeople were asked to invite 8 - 12 respondents of childbearing age to take part with an equal balance of women's group members and non-members and women and men to help access a range of views. A total of 280 respondents took part in the focus groups discussions. On average these respondents were 36 years old and had 5 children. Approximately 83% were of Chewa ethnicity, almost two-thirds (63%) were female and just over half (55%) were group members. As well as community members a number of respondents fulfilled a range of different specific roles in their communities (table 4q - page 168 to 171).

Figure 4q: Characteristics of respondents of FGDs conducted between July 2010 and December 2010

Schedule	Group	Respondents	Age	Gender	Ethnicity	Parity	Group membership	Respondents with key roles
Participation	2905	12	23 – 54 x = 36.1	F = 7 M = 5	Chewa = 12	1 – 12 x = 5.7	Yes = 6 No = 6	Group chairlady Group members Community members Zonal chairlady Church secretary Chief advisers VH
	4104	12	18 – 44 x = 29.6	F = 9 M = 3	Chewa = 12	1 – 10 x = 4.0	Yes = 8 No = 4	Group vice-chairman Group secretary Group members Community members Chairman of Malawi carer
	0903	11	20 – 65 x = 42.2	F = 9 M = 2	Chewa = 10 Senga = 1	1 – 15 x = 6.5	Yes = 7 No = 4	Group chairlady Group secretary Village facilitator Group members Community members Pre-school teacher Health facilitator Borehole mechanic VH
Leadership	1701	11	22 – 54 x = 38.5	F = 6 M = 5	Chewa = 11	1 – 8 x = 5.1	Yes = 5 No = 6	Group chairlady Group secretary Group members Community members Church development chairman Bereavement committee member Sub-GVH
	1006	10	21 – 35 x = 27.6	F = 7 M = 3	Chewa = 9 Ngoni = 1	0 – 6 x = 3.3	Yes = 6 No = 4	Group chairlady Group members Community members
Organisational structures	0206	11	22 – 55 x = 35.3	F = 5 M = 6	Chewa = 11	2 – 10 x = 5.2	Yes = 7 No = 4	Group chairlady Group secretary Group treasurer Community members VH
	4505	11	21 – 51 x = 28.8	F = 6 M = 5	Chewa = 11	0 – 9 x = 2.7	Yes = 5 No = 6	Group secretary Group members Community members VH
	2301	10	35 – 64 x = 46.9	F = 6 M = 4	Chewa = 10	2 – 11 x = 8.1	Yes = 6 No = 4	Group chairlady Group secretary Group treasurer Group members Community members Zonal chairlady GVH
	2508	8	25 – 63 x = 40.9	F = 6 M = 2	Chewa = 4 Ngoni = 3 Lomwe = 1	2 – 10 x = 5.3	Yes = 3 No = 5	Village facilitator Group members Community members

Schedule	Group	Respondents	Age	Gender	Ethnicity	Parity	Group membership	Respondents with key roles
Needs assessment	3802	11	32 – 67 x = 46.2	F = 5 M = 6	Chewa = 11	3 – 12 x = 6.7	Yes = 7 No = 4	Group chairlady Group chairman Group members Community members Village facilitators Chief's counsellor VDC secretary Village granary treasurer VH
	2304	10	20 – 46 x = 30.2	F = 6 M = 4	Chewa = 10	1 – 8 x = 4.2	Yes = 5 No = 5	Group chairlady Group members Community members Village cooperative secretary Sanitation committee secretary Orphanage teacher Zonal chairlady Village facilitator
Asking why?	3603	13	20 – 50 x = 30.0	F = 6 M = 7	Chewa = 13	2 – 6 x = 4.0	Yes = 7 No = 6	Group chairlady Group vice-chairman Group secretary Group members Community members Bicycle ambulance driver Village facilitator VH
	3703	11	20 – 55 x = 35.2	F = 9 M = 2	Chewa = 11	1 – 10 x = 5.1	Yes = 6 No = 5	Group chairlady Group secretary Group treasurer Group members Community members Village savings and loans chairlady Village savings and loans treasurer
	3404	8	23 – 49 x = 32.6	F = 5 M = 3	Chewa = 2 Lomwe = 3 Yao = 3	2 – 9 x = 5.9	Yes = 5 No = 3	Community members Group chairlady Group secretary Zonal secretary Nodal secretary VH

Schedule	Group	Respondents	Age	Gender	Ethnicity	Parity	Group membership	Respondents with key roles
Resource mobilisation	1506	12	23 – 55 x = 35.8	F = 9 M = 3	Ngoni = 6 Chewa = 4 Lomwe = 2	1 – 10 x = 5.0	Yes = 7 No = 5	Group chairlady Group members Community members Village social committee members VH counsellor Village facilitators
	3302	8	24 – 63 x = 45.9	F = 7 M = 1	Chewa = 8	4 – 12 x = 7.6	Yes = 4 No = 4	Group chairlady Group secretary Group members Community members GVH
	0107	13	20 – 62 x = 39.1	F = 7 M = 6	Ngoni = 8 Chewa = 3 Senga = 1 Wiza = 1	2 – 16 x = 7.2	Yes = 8 No = 5	Group chairlady Group vice-chairlady Group secretary Group members Community members Community policing committee member Chief's secretary VDC chairman VH
Links with others	1102	8	22 – 48 x = 36.4	F = 4 M = 4	Chewa = 8	2 – 10 x = 6.0	Yes = 5 No = 3	Group vice-chairlady Group advisor Group members Community members GVH representative
	2505	12	20 – 59 x = 37.8	F = 10 M = 2	Ngoni = 6 Chewa = 3 Yao = 1 Tumbuka = 1 Mang'anja = 1	2 – 12 x = 4.8	Yes = 7 No = 5	Group secretary Girl's counsellors Group members Community members Zonal chairperson School committee member Village counsellors
	4205	12	21 – 59 x = 35.3	F = 8 M = 4	Chewa = 12	1 – 8 x = 4.3	Yes = 7 No = 5	Group chairlady Group vice-chairlady Group secretary Group members Community members Community police chairman VDC chairman VDC secretary ITN distributor VH

Schedule	Group	Respondents	Age	Gender	Ethnicity	Parity	Group membership	Respondents with key roles
External agent	2902	12	21 – 56 x = 30.3	F = 7 M = 5	Chewa = 12	1 – 7 x = 3.3	Yes = 5 No = 7	Community members Group chairlady Group secretary Village facilitator Village initiation counsellor Group vice-chairman Bicycle ambulance rider Nodal secretary Zonal committee member District committee member
	0205	9	21 – 35 x = 28.4	F = 6 M = 3	Chewa = 8 Ngoni = 1	1 – 6 x = 4.1	Yes = 4 No = 5	Community members Group secretary Group treasurer Bed net distributor
	4507	13	28 – 62 x = 47.7	F = 8 M = 5	Chewa = 13	4 – 12 x = 6.6	Yes = 7 No = 6	Group chairlady Group vice-chairlady Group secretary Group members Community members GVH secretary VH
Programme management	2403	9	29 – 49 x = 35.8	F = 6 M = 3	Chewa = 9	2 – 9 x = 5.6	Yes = 5 No = 4	Group chairwoman Group members Community members Village facilitator
	1205	11	22 – 33 x = 27.5	F = 7 M = 4	Chewa = 11	2 – 7 x = 3.9	Yes = 7 No = 4	Group secretary Group members Community members Village savings and loans treasurer
	2506	12	21 – 63 x = 36.8	F = 6 M = 6	Ngoni = 9 Chewa = 3	2 – 9 x = 5.2	Yes = 6 No = 6	Group vice-chairlady Group secretary Group vice-secretary Chief's wife Village secretary Village savings and loans chairman Red cross volunteer Group members Community members VH
Total	NA	Total = 280 x = 10.8	20 – 67 x = 36.0	F = 177 M = 103	Chewa = 231 Ngoni = 34 Senga = 2 Tumbuka = 1 Mang'anja = 1 Yao = 4 Wiza = 1 Lomwe = 6	0 – 16 x = 5.2	Yes = 155 No = 125	NA

#### **4.4.4 Data management methods**

Data from FGDs was audio recorded and observation notes were recorded in field notebooks. Recordings were transcribed into Chichewa by two Chichewa speakers (MK and AM) and subsequently translated into English by CK and NM who are both bilingual Chichewa/English speakers. All individuals involved in data collection, transcription and translation (MK, AM, CK and NM) met with MR to review each translation together to ensure accuracy and conceptual, grammatical and syntactical equivalence. The verified English translation of each of the FGDs and associated observations were subsequently transcribed into Microsoft Word (Microsoft Corporation) documents. Data from unstructured and semi-structured participant and non-participant observations and associated informal conversations and interactions was recorded in detail in 30 field notebooks (approximately 6000 pages) as text, maps and diagrams. Pertinent extracts from these notebooks were identified and transcribed into Microsoft Word (Microsoft Corporation) documents. Pertinent maps and diagrams were scanned into Adobe PDF documents (Adobe Software Systems Incorporated). All intervention documentation was collated and filed. Pertinent extracts were identified and transcribed into Microsoft Word (Microsoft Corporation) documents.

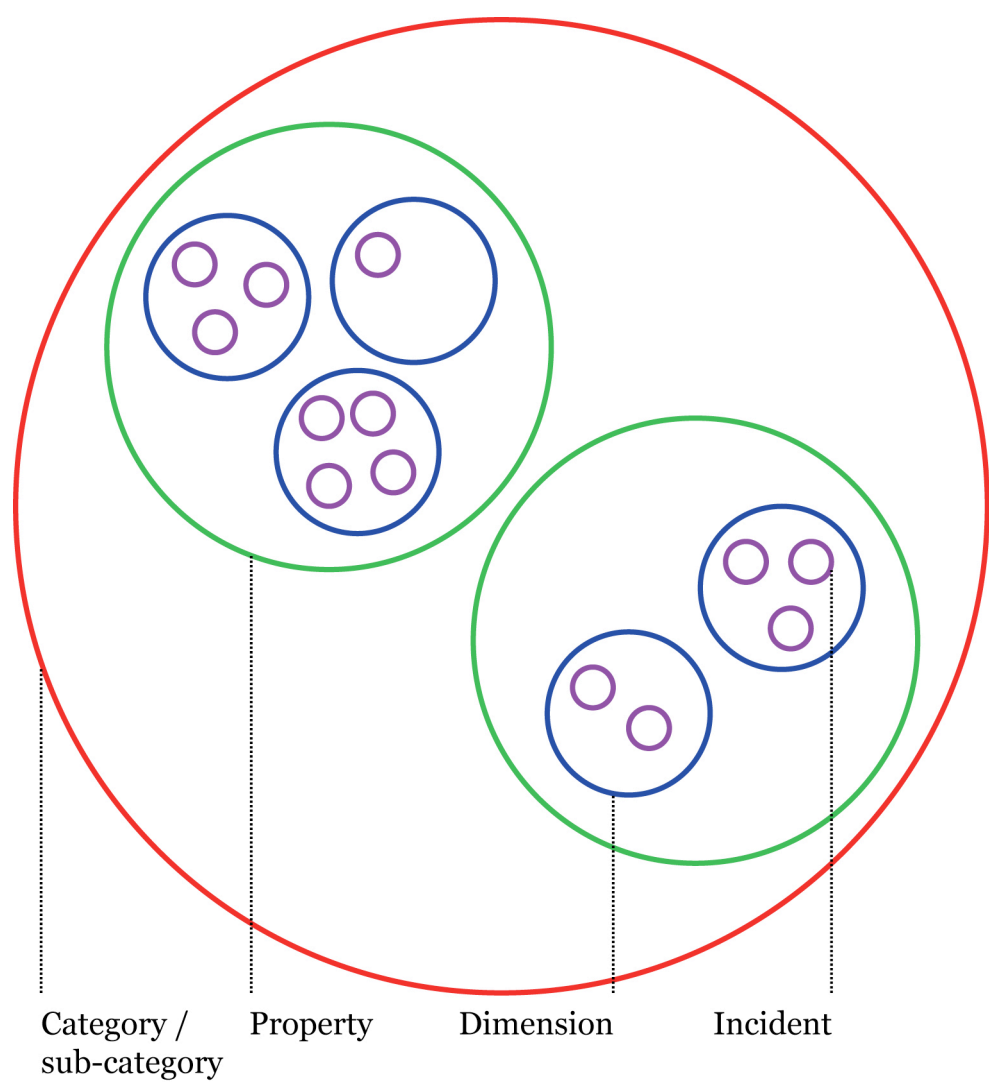
#### **4.4.5 Data analysis methods**

All qualitative data, in Microsoft Word documents (Microsoft Corporation) and Adobe PDFs (Adobe Software Systems Incorporated), from unstructured and semi-structured participant and non-participant observations, FGDs and intervention documents was imported into ATLAS.ti 6 (ATLAS.ti Scientific Software Development GmbH) as it became available. ATLAS.ti 6 was used to facilitate the qualitative data analysis process. Data analysis began after the first observation had taken place in phase 1 of the thesis and continued in parallel to further data collection and literature review in phase 1, 2 and 3. In this way the data analysis process was both guided by the data collected and literature reviewed and itself guided what data should be collected and what literature should be reviewed.

The data was analysed in three overlapping stages using a constant comparison method. In the first stage the aim was to develop categories and thus the data was fractured into as many incidents as possible and gradually organised into categories. This was achieved by coding incidents (illustrations of a category in the data) in a unit of data into categories (basic theoretical concepts that help to explain and predict behaviour) and then comparing them first with other incidents in the same unit of data and then with incidents in other units of data to see if they fitted within these categories or constituted a new category. Through these comparisons the categories gradually became more precise and clearly differentiated from each other as their properties (characteristics common to all concepts in a category) and dimensions (the position of a property along a continuum or range) began to emerge (Figure 4r - page 173).



Figure 4r: Incidents, dimensions, properties and categories



In the second stage the aim was to integrate categories and their properties by putting back together the fractured categories that were developed in the previous stage. This was achieved by comparing incidents in the data with the properties and dimensions of categories that had already been identified and using this to integrate and relate the categories together. Again these comparisons took place within a unit of data and between units of data. Through these comparisons the core of the grounded theory began to form as the categories became more abstracted and located in a unified whole.

In the third stage the aim was to delimit the grounded theory and categories. This was again achieved through constant comparison within a unit of data and between units of data and through an awareness of theoretical saturation. The categories were delimited by gradually cutting down the categories to only those that were most relevant and saturating these by only coding incidents applicable to this smaller set of categories when they added a new aspect to the categories or further integrated the categories. The theory was then solidified and delimited through reformulation with smaller sets of higher-level abstract concepts in a reductive process until this too became saturated.

These three stages were conducted after each round of data collection within each of the three phases of the thesis (figure 4h - page 150). However, due to the status of the emerging theory, there was more emphasis on category development in phase 1 and 2, category integration in phase 2 and 3, and theory delimitation in phase 3.

In parallel with these three stages, as theoretical propositions about categories and properties and relationships between categories began to emerge, they were recorded as ‘memos’. These ‘memos’ helped to guide data collection, analysis and literature review and to develop and integrate categories and delimit theory and categories.

The analysis helped to develop an emergent theory which has been presented in chapter 8 based on findings presented in chapters 5 (how women’s group members became more organised and mobilised to address the social determinants of MCH), 6 (capacities built by the MaiMwana women’s group intervention) and 7 (interpersonal resources and relationships that were generated through women’s group members becoming more organised and mobilised). Quotations to support findings in chapters 5, 6 and 7 are referenced in the following formats. FGDs are referenced as: (FGD - women’s group ID - date). Observations are referenced as: (OBS - field notebook number - page - date).

#### **4.4.6 Ethical considerations**

This thesis is a component of the women’s group process evaluation that was carried out by MaiMwana Project within its cluster randomised controlled trial design. Ethical permission for the trial was granted by the Malawi National Health Sciences Research Committee in January

2003 (Ref: MED/4/36/I/167) and the ethics committee of the UCL Institute of Child Health and Great Ormond Street Hospital. It is registered with ISRCTN06477126.

In 2004 verbal and written consent for the trial was received from community leaders after full consultation and discussions. The regional, district and village leaders, and local health and development professionals had ongoing access to the research programme and were the first to be briefed on thesis findings and outcomes through written and verbal reports.

Individual verbal informed consent was acquired from the participants in every women's groups that was observed before in vivo observation or video recording for extra vivo review. The informed consent process involved explaining the process to be undertaken and the advantages and disadvantages of taking part. Participants were also informed that their participation was voluntary and that they could stop taking part at any time. Finally, participants were assured that the information collected would be confidential and any analysis or reports would maintain the anonymity of individuals involved. A similar informed consent process was undertaken with participants before each FGD to gain consent both to conduct the discussion and to audio record the discussion (appendix 3).

Verbal consent to observe training sessions, team nodal meetings, team head office meetings, management meetings, directors meetings and other meetings was acquired from the project directors and project manager before commencement of the thesis. Verbal consent to examine secondary information in intervention documents was also sought from the same individuals before commencement of the thesis.

#### **4.4.7 Research relationship**

In January 2005, as a 27 year old white, male, European graduate with experience of working with children in difficult circumstances in London and across the UK, I was employed as a research fellow at the UCL Centre for International Health and Development and seconded to MaiMwana Project in Malawi as a technical advisor. My role was threefold. First, I developed the MaiMwana women's group intervention approach and trained and supported a team of five Malawian supervisors and 24 ZFs to facilitate and monitor the 200 groups in Mchinji district. Second, I designed the MaiMwana process evaluation and trained and supported a team of three Malawian researchers to collect, manage, analyse and write up the findings. I was also involved in coordinating the work of the impact evaluation team when the second technical advisor was not in Malawi. Finally, although I had no direct line management responsibility, in collaboration with the second technical advisor and the Malawian management team, I was involved in managing all aspects of MaiMwana project. These roles led me to live in Mchinji Boma, a trading centre of approximately 6000 people and the site of the project office, for approximately 11 months per year and travel frequently and extensively across the district.

This long-term, immersive and intense association with MaiMwana Project and Malawi has given me the opportunity to learn Chichewa, gain some understanding of Malawian culture and develop deep, lasting and real relationships with the MaiMwana Project family and members of communities and women's groups in Mchinji. Thus, although I am not of the same nationality, ethnicity, background or often gender, as the subjects of this thesis, my association with Malawi has provided me with intimate access to the experiences of community members involved in the women's groups. Indeed, I am privileged to have reached a stage where I feel accepted, trusted and cared for as a member of these communities - who call me Mr. Banda - despite coming from outside them. This acceptance has made me passionate about building the capacities of Malawian communities to take social and political action to address inequalities in health, to care deeply for Malawi and all its eccentricities and to love MaiMwana Project and all the people and communities involved in it.

#### **4.4.8 Techniques used to enhance the rigour of the thesis**

Given the variations inherent in, and subjectivity attached to, qualitative research practice it is necessary to take further steps to ensure rigour. Beck (1993) proposed credibility, auditability and fittingness as three main standards of rigour specifically common to qualitative methods, rather than any specific research methodology. Below I will present the 10 methods of research practice used in this thesis to address these three standards.

##### **Credibility**

The most important characteristic of a program theory is that it should be plausible (i.e., having the outward appearance of truth, reason, or credibility) (Donaldson and Lipsey, 2006). In qualitative research credibility is demonstrated when informants and readers who have had the human experience recognise the described experiences as their own (Beck, 1993).

Five methods were used to help to ensure credibility in this thesis. First, participants were involved in guiding the process of inquiry. The literature reviewed, questions asked and samples selected in each phase was based on emergent findings coming from the analysis of information provided by participants in the previous phase(s). Second, periodically during, and particularly at the conclusion, of the analysis the constructed theory and codes were checked and verified with participants to ensure their relevance. Third, participants' own language was used at all levels of coding. To ensure that the participant's meaning of the word was not distorted or inaccurately represented, where possible, direct quotes were used in the results sections. Fourthly, my personal views (MR) and those of my research assistants (CK and NM) were recorded throughout and used during analysis to prevent bias. This was done by: writing a personal journal recording my views regarding the phenomenon under investigation; writing post-discussion notes detailing the context and any particularly interesting occurrences; and clearly describing the purpose of the literature reviewed. In particular I took great care to carefully consider and record the impact of my nationality, ethnicity, background, role in

MaiMwana Project, relationships in Malawi and gender on the process of data collection, analysis, interpretation and write-up. Finally, different data collection methods, including participant and non-participant observation, FGD and review of secondary data, provided 'slices of data' (Glaser and Strauss, 1967). Using these different methods is beneficial as they can supplement each other, provide mutual verification and provide different forms of data on the same subject allowing for comparison and thus the generation of a more credible theory.

### **Auditability**

Auditability is the extent to which another researcher can follow the methods and conclusions of the original researcher (Carpenter Rinaldi, 1995).

Three methods were used to help ensure auditability in this thesis. First, before approaching the data I delineated standard questions that I consistently asked in the identification, development and refinement of all codes. These included: a) what is happening in the data?; b) what does the action in the data represent?; c) is the conceptual label or code, part of the participants vocabulary; d) in what context is the code/action used; e) is the code related to another code; f) is the code encompassed by a broader code; and g) are there codes that reflect similar patterns? These were derived from Glaser (1978), Strauss (1987), and Strauss and Corbin (1990). Second, to determine the relationship of each code to the overall theory I used a consistent format for coding. This 'paradigm model' guided the asking of standard questions of the data which included: a) to which domain is the code relevant?; b) within that domain is the code an input/activity (resources and materials provided by the intervention and activities provided by the intervention)?; c) within that domain is the code an immediate outcome (characteristics of the participants that change as a result of the intervention inputs/activities)?; d) within that domain is the code an intermediate outcome (the behaviour changes that follow the immediate changes in knowledge, awareness, skills, opportunities and attitudes)?; and e) within that domain is the code a long-term outcome (global changes and community impacts as a result of the intermediate behaviour changes)? Finally, how and why the participants in the thesis were selected was clearly outlined.

### **Fittingness**

Fittingness or transferability is the extent to which the research findings have meaning to others in similar situations (Carpenter Rinaldi, 1995).

Two methods were used to help ensure fittingness in this thesis. First, the parameters of the research in terms of the sample and setting were clearly delineated. Second, to demonstrate the probability of the research findings having meaning to others in similar situations, the literature on similar interventions was reviewed in chapters 2 and 3. Furthermore, an exploration of the similarities and differences between the findings of this thesis and previous theoretical constructs in the literature was undertaken in chapter 8.

#### 4.5 Selected publications, films and photographs of relevance to this thesis

Appendix 4 contains abstracts of selected peer reviewed publications, published to date, that relate to the findings presented in this thesis. Associated documentary films and photographs exhibitions are included in a DVD attached to the back cover of this thesis.

##### Peer reviewed publications

1. **Rosato M**, Malamba F, Kunyenge B, Phiri T, Mwansambo C, Kazembe P, Costello A and Lewycka S. Strategies developed and implemented by women's groups to improve mother and infant health and reduce mortality in rural Malawi. *International Health (In press)*.
2. **Rosato M**, Mwansambo C, Lewycka S, Kazembe P, Phiri T, Malamba F, Newell ML, Osrin D and Costello A. MaiMwana women's groups: a community mobilisation intervention to improve MCH and reduce mortality in rural Malawi. *Malawi Medical Journal*. December 2010; 22(4): 112 – 119.
3. Lewycka S, Mwansambo C, Kazembe P, Phiri T, Mganga A, **Rosato M**, Chapota H, Malamba F, Vergnano S, Newell ML, Osrin D and Costello A. A cluster randomised controlled trial of the community effectiveness of two interventions in rural Malawi to improve health care and to reduce maternal, newborn and infant mortality. *Trials* 2010; 11: 88.
4. **Rosato M**, Lewycka S, Mwansambo C, Kazembe P and Costello A. Women's groups' perceptions of neonatal and infant health problems in rural Malawi. *Malawi Medical Journal* 2009; 21 (4): 168 – 173.
5. **Rosato M**, Laverack G, Howard-Grabmann L, Tripathy P, Nair N, Mwansambo C, Azad K, Morrison J, Bhutta Z, Perry H, Rifkin S and Costello A. Community participation: lessons for MCH. *Lancet* 2008; 327: 962-71.
6. **Rosato M**, Mwansambo CW, Kazembe PN, Phiri T, Soko QS, Lewycka S, Kunyenge BE, Vergnano S, Osrin D, Newell M-L and Costello A. Women's groups' perceptions of maternal health problems in rural Malawi. *Lancet* 2006; 368: 1180-88 .

##### Films and photographs

7. **Rosato M** and Otanez M. Umodzi [DVD]. London: UCL, Centre for International Health and Development; 2010. 1 DVD: 14 min., sound, colour, HD. Available from: <https://vimeo.com/12427420>
8. **Rosato M**. Chimvano cha mabvu [slide]. London: UCL, Centre for International Health and Development; 2010. 35 slides: sound, colour. Available from: <http://vimeo.com/18396454>

9. **Rosato M.** M+E= [DVD]. London: UCL, Centre for International Health and Development; 2011. 1 DVD: 12 min., sound, colour, HD. Available from: <https://vimeo.com/25027515>

## **Chapter 5: Results - How women's group members organised and mobilised themselves**

### **5.1 Chapter overview**

The data shows that community members: participated in women's groups, assessed their MCH problems, developed local leaders, formed organisational structures, mobilised resources, linked with other people and organisations, identified the root causes of their health problems, created equitable relationships with MaiMwana Project, and took control of programme management.

This succeeded in organising and mobilising women's group members by: allowing them to come together with others in similar circumstances (5.2), helping them to identify common concerns and solutions (5.3), providing them with direction and structure (5.4), organising them to socialise and address broader concerns (5.5), enabling them to mobilise necessary resources and use them prudently (5.6), enabling them to form partnerships, coalitions and alliances with others based on shared goals (5.7), developing their critical consciousness of the root causes to their MCH problems and actions to address them (5.8), transferring power to them to take control of the programme (5.9), and taking control over decision-making in relation to the programme (5.10).

### **5.2 Participation in women's groups**

#### **5.2.1 Extent of participation**

In many communities, members participated extensively in women's groups. A total of 7721 (6975 women and 740 men), 4678 (4678 women), 9696 (7602 women and 2094 men) and 7384 (5821 women and 1563 men) women and men attended meetings in phase 1, 2, 3 and 4 respectively suggesting that over 10,000 community members became members of women's groups out of a total population of approximately 72,000 (including 24,175 women of childbearing age) in intervention clusters.

In contrast, in a few other communities, the participation of women's group members was more limited. In some cases, participation started well but deteriorated over time to the extent that six groups even disbanded due to lack of members.

*“As we were meeting as a group, some of us started saying that the grouping was useless. As a result of this, the numbers started dropping till there were only about five to eight of us remaining and finally we stopped meeting all together” (FGD - 4104 - 23.08.10)*



### **5.2.2 Diversity of participation**

In most communities, a range of different groups were represented amongst the participants in women's groups. The most commonly participating group were women who had previously been, or were currently, pregnant. Also well represented were men, community leaders, extension workers from other government and non-governmental organisations, and other stakeholders.

*"I am village headman Chidangwe, I am one of the participating members of this women's group" (FGD - 2905 - 18.10.10)*

In these communities, the most commonly underrepresented group was women who had never given birth including those below and above childbearing age.

### **5.2.3 Characteristics of participation**

Usually women's group members took an active part in discussions which were conducted in an egalitarian and democratic manner ensuring that they all had an opportunity to share their views and be involved in decision-making.

*"All the decisions that we make on our group are through collective participation and contribution. There is no one who is above the group in terms of decision making. We sit down and discuss and everyone is free to contribute anything, we debate and reach a consensus. It's not only one woman who is involved in the decision making but all of us...when we are taking part in these activities, there is freedom of participation; all people are equally taking part in the decision making. There is no one who put others under oppression...there was freedom to the extent that every member was free to participate and contribute ideas and debated on. There was freedom of expression of ideas" (FGD - 2905 - 18.10.10)*

## **5.3 Problem assessment in women's groups**

### **5.3.1 Problems, contributing factors, solutions and strategies identified**

In most communities problem assessment by women's group members succeeded in identifying a wide range of maternal and neonatal and child health problems. In total 78 different maternal health problems ( $x = 13$ ; range = 4 - 29) and 85 different neonatal and child health problems ( $x = 15$ ; range = 5 - 32) were identified.

In contrast, in a few other communities, women's group members failed to identify many maternal and neonatal and child health problems. In some cases as few four different maternal and five different neonatal and child health problems were identified.

After identifying problems, members prioritised those that they felt were most important and required attention.

*“We were doing all the problem assessment, prioritising and strategizing during the group meetings. We have the stipulated days and time that we always meet. Everyone who is a MaiMwana women's group participant is aware where and when to meet. These are the days that we discuss all the MCH problems, how to prioritise and strategize. This is the only forum whereby everyone is free to raise any point, all the suggested decisions in how we may have solutions to them. That's why we managed to prioritise the five most needs in our community” (FGD - 3802 - 09.09.10)*

The maternal health problems most commonly prioritised included: haemorrhage, anaemia, retained placenta, malpresentation, obstructed labour, malaria, diseases of hypertension, stillbirth, ruptured uterus, sexually transmitted infections (STIs), miscarriage, prolonged labour, breast problems, sepsis and HIV/AIDS. The neonatal and child health problems most commonly prioritised included: diarrhoea, sepsis, preterm birth, tetanus, malaria, asphyxia, hypothermia, respiratory tract infections, jaundice and convulsions.

After prioritising problems, members identified the factors which contributed to them. The large majority of contributing factors identified were behavioural risk factors associated with inadequate or inappropriate maternal and child care and care-seeking behaviours.

*“With the active involvement of the group we realized that the main root cause of different pre- and post-natal delivery problems are being influenced by delivering at TBAs. We had a surveillance to know what happens at the TBAs, of which we established that there are no pre- and post-natal checks, the delivery condition is not conducive, and there is poor sanitation and no equipments. This prompted us to ask the whole community to be going to the antenatal and delivering at the hospitals.” (FGD - 3603 - 07.10.10)*

Physiological risk factors were also sometimes identified.

*“As we were involving ourselves in discussing the causes of malaria, we realized through the group meetings that malaria comes because of mosquito bites” (FGD - 3603 - 07.10.10)*

Members also identified a range of socio-environmental risk factors underpinning their MCH problems. These are discussed in more detail in section 5.8 below.

They went on to identify solutions to prevent the contributing factors and to manage their maternal, neonatal and child health problems if they arose.

*“The solutions for all the MCH problems are assessed through the group meetings. We call for a group meeting, have a process of discussion on all the health problems and getting the possible solutions” (FGD - 3802 - 09.09.10)*

Finally, members identified locally feasible strategies to implement these solutions in practice.

*“We identified and prioritised five of the most needs. We prioritised the problem of asphyxia and convulsions in children and pregnant mothers. Now after doing a rigorous assessment through the participatory group meetings, we realized that asphyxia and convulsions was not the problem on itself. This was coming as a result of malaria. We removed asphyxia and convulsions on the list of five problems and we added malaria. We started discussing how we can prevent this malaria problem. We used the group meetings to discuss what we need to do. We opted for the using of bed/mosquito nets all the time we are sleeping. Now...we are discussing the ways and means of accessing the mosquito nets...the other solution was to improve sanitation in our homes; we should not have swamps and pits around our homes to reduce the breeding of mosquitoes. We should be cutting the grass around our homes” (FGD - 3802 - 09.09.10)*

Twenty one different strategies were identified including: health education, bicycle ambulances, TBA training, dimba garden cultivation, distribution of ITNs, static and mobile antenatal and under five clinics, small scale income generating activities (IGAs), distribution of oral rehydration solution, group funds, distribution of family planning methods, non-health education, lobbying for a health surveillance assistant (HSA), encouraging VCT attendance, forestry, adult literacy classes and childcare centres.

### 5.3.2 Characteristics of the problem assessment

In most communities problem assessment was carried out in an open manner which encouraged women's group members to freely share their experiences and opinions about MCH problems, solutions and strategies.

*“The other thing that I should comment is that we are having interest in participating in MCH activities. We are able to discuss openly on groups on issues affecting mothers and children. We have learnt a lot through these MCH groups. We are free to discuss, exchanging facts and making decisions by ourselves. This group is an asset to us in managing MCH problems...our confidence in MCH activities has really changed as we are able to share ideas during our meetings, whenever we are discussing we all participate freely, no one feels intimidated” (FGD - 3802 - 09.09.10)*

Problem assessment was also carried out in an inclusive manner encouraging different groups within the community to share their experiences and opinions. This primarily included women's group members but also drew on the experiences and opinions of non-group members.

*“We were doing this assessment at village level because we were equally convinced that every woman must have been affected with one problem or the other. So, we wanted every woman to share about these problems” (FGD - 2304 - 14.09.10)*

In this way problem assessment succeeded in representing the issues of importance to all community members rather than just those of a select group who attend the women's groups.

*“The decisions [about problems and solutions identified and prioritised] are made on the group, we don't involve [only] some selected individuals and the decisions do not concern one individual or particular a committee. It's for the whole group and the rest of the community” (FGD-3802-09/09/10)*

Finally, problem assessment was conducted in a democratic manner ensuring that the views of all women's group members were treated equally. To achieve this all members had an equal vote in deciding which problems, solutions and strategies to identify and prioritise.

*“There is equal participation in assessing the MCH needs. Decision making is not solely in one or two individuals, all are free to*

*contribute. Whenever we see that a decision is not worthy to be implemented we argue so that the best option should be reached” (FGD - 3802 - 09.09.10)*

In contrast in a few other communities, problem assessment was less inclusive and only considered the views of current members of the groups who were generally women who had been or were currently pregnant. Other groups such as men, women who had never been pregnant and non-women’s group members were not encouraged to share their experiences and opinions.

*“Facilitator: You told me that during the time that you were doing the assessment there were only group members, were there any other people apart from the group members?*

*Respondent: No, there were only group members” (FGD - 2304 - 14.09.10)*

## **5.4 Local leadership of women’s groups**

### **5.4.1 Types of local leaders**

In most communities local leaders of women’s groups included subgroup, group and area level committee office and vice-office bearers such as chairpeople, secretaries and treasurers. In the second cycle of the women’s groups they also included VFs.

*“Yes, the committee [members] that we have are empowered to take charge of different group activities...these committee [members] act as our torchbearers to our health problems; they assess our health problems at a committee level and then liaise with the group and identify the possible benefactors to our problems” (FGD - 2403 - 29.10.10)*

These local leaders were predominantly female, particularly at the beginning of the women’s group cycle, but over time male local leaders became increasingly common.

*"In many groups men now taking on some role in committees. Women still have greater membership but strong men seem to help to get things done. For strategies to work well these individuals are necessary and are built by the group and its momentum" (OBS - 17 - 74 - 05.10.07)*

Local leaders were elected from within the women's group membership either because they had specialist knowledge of MCH issues or because they were well respected in communities due to their previous experiences or culturally defined status.

"Opinion leaders with specialist knowledge...people follow them because of their knowledge. Opinion leaders with no specialist knowledge...people follow them because they are role models. They are followed because they are respected for their experiences" (OBS - 9 - 6 - 25.01.06)

#### **5.4.2 Roles of local leaders**

In most communities local leaders acted as change aides supporting the work of the ZFs. Over time they took on more responsibility as change agents themselves.

"Women's groups generate opinion leaders on several levels: committee members; group members; VFs - these individuals act as change aides and change agents in their communities and passively and actively share 'help' with others. This develops a local leadership that was absent before the groups existed....which builds individual and community capacity to deal with problems and provides a resource to do this" (OBS - 11 - 136 - 23.11.06)

They fulfilled a wide range of roles in women's groups. Their overarching role was to provide strategic direction and coordination to ensure that groups were implemented effectively.

*"Yes, for each and every group to function well there is a need of having leaders, so in case of our group here, we do have the chairlady who is a core centre of all activities that we do" (FGD - 1006 - 30.10.10)*

This included bonding and encouraging women's group members to work together through the group to achieve improvements in MCH.

*"Yes, she [the chairlady] was emphasizing much on unity amongst us. She was saying that whenever there is unity we will prevail in our activities" (FGD - 1006 - 30.10.10)*

They also organised the day-to-day logistics of groups including: forming groups, setting the agenda for meetings, recruiting members and setting membership criteria, planning the time and location for meetings, and taking minutes and writing reports.

*“I [the chairlady] am also the patron of all the activities that they are doing, wherever I give some advices if possible. I also take the role of wooing people that are not part of the women’s group to join so that the mother and child problems that we are having should be reduced” (FGD - 2905 - 18.10.10)*

These logistics also included providing supervision and line management of group members and other leaders, including the delegation of responsibilities and resolution of conflicts.

*“It is her [the chairwoman’s] responsibility to call for meetings and delegate her members on various activities like door-to-door visits. This, I am sure is done because we see them visiting different households” (FGD - 1701 - 25.08.10)*

Local leaders also had a role in facilitating women’s group meetings and discussions. In the early stages of the women’s groups the local leaders would, because of their experience, share information to help stimulate and facilitate discussions during meetings. In a sense they had a role as an information resource about MCH and other related issues.

*“Yes, they meet these objectives. On every meeting, these leaders remind and advise us on the issues of MCH and mortality” (FGD - 1701 - 15.08.10)*

In later stages they took on more responsibility for facilitating the meetings themselves. Indeed in the second cycle of the women’s groups the VFs officially took responsibility for facilitating the women’s groups from the ZFs.

*"Responsibility for facilitation of groups is being handed over to VFs. Two women and one man in each group. Volunteers will receive materials, training and supervision" (OBS - 24 - 159 - 10.06.08)*

Local leaders also had a range of roles in guiding the implementation of strategies including: lobbying necessary resources, managing implementation, and monitoring and evaluating the strategies.

*"Elected a leader for dimba committee. The leader's role is to ensure that garden activities are well conducted and in line with plans and to ensure unity amongst members to make sure the whole activity is easier" (OBS - 22 - 150 - 02.10.08)*

In guiding the implementation of the strategies some local leaders also had a role in looking after collective assets mobilised by the women's groups.

*“Okay, the treasure was keeping the money of this group raised through different means either piece works or contributions. The treasure had to know how much money the group is having. Whenever there is any activity that needed of money, the treasure was meeting with the secretary and chairlady to see how much they can take from their savings and how much is remaining” (FGD - 1006 - 30.10.10)*

Another role they had was in liaising with other MCH stakeholders, within and outside the community, to establish relationships.

*“It was the women's group that was involved in the establishment of the links; of course the chairperson was the lead person. The chairperson was mostly involved running up and down making sure that the partnerships are established” (FGD - 1102 - 21.10.10)*

Beyond the women's groups, the local leaders also had a role in representing the women's groups and their interests with stakeholders at fora such as area development committee and village development committee meetings.

*“Okay, we [the leaders] are really accountable to the community on all the activities that we are participating by going around the villages to conduct community meetings, we also go to attend community meetings at a higher level...the Village Development Committee where we actually present what we are doing and what the community needs to do as part of their activities” (FGD - 2905 - 18.10.10)*

They also represented women's groups within their communities as a whole. In this role they communicated what the groups are doing to the wider community and encouraged them to participate more actively in groups and other MCH activities.

*“Whatever we were doing on this group was being connected to the community. All the activities that were being done targeted the health of all mothers and children. The chairlady was taking everything from the group to encourage participation.” (FGD - 1006 - 30.10.10)*

Finally, local leaders also supported other community members in their MCH needs. This support was sometimes emotional but more commonly tangible, such as providing money and



resources, or advice and information about MCH. Advice and information was provided to male and female non-group members on MCH problems, factors that contribute to them, solutions, and knowledge specific to activities being undertaken.

"Group members transfer knowledge, skills and understanding beyond the group to their community including to non-group members. Group members feel it is their role to spread information...they have taken on this responsibility" (OBS - 8 - 154 - 14.12.05)

The advice and information provided was often learnt through the women's group meetings, and was provided both informally at chance meetings and formally through systematic visits to the homes of other community members.

### **5.4.3 Local leadership styles**

In many communities local leaders showed a real dedication and commitment to leading the women's groups.

*"The other change is that women have committed themselves to safe motherhood because of the unceasing commitment and dedication by our leaders. These leaders make door to door visits regularly, this motivates the women to practice safe motherhood. And indeed there is reduced mortality" (FGD - 1701 - 25.08.10)*

They were also considered, by other community members, to be knowledgeable, hardworking and active in their leadership.

*"No, she does not just sit and wait for reports but she also takes part in the work herself so much so that all of us feel proud of having such a chairperson" (FGD - 1701 - 25.08.10)*

These leaders generally did not position themselves as superior to the other women's group members. Instead, they led in a non-hierarchical and egalitarian manner ensuring that all members had the opportunity to participate in decision-making.

*"No, this does not happen [making decisions for group members]. These people [the leaders] actually work for us. They serve us instead of bossing. They really do their work as servants of the people" (FGD - 1701 - 25.08.10)*

In many cases the local leaders also clearly and transparently worked for the best interests of the group members, and ultimately the whole community, rather than for personal gain.

*“No, our treasurer is effective. However, we don’t have enough money that we can talk of banking. The only money we have is used for the maintenance of the bicycle ambulance and whenever we need some we go to the treasurer and withdraw for such activities. We have never complained of any thing for the many years that we have been with him. He is accountable and transparent” (FGD - 1701 - 25.08.10)*

Finally, women’s group members, and more broadly, community members, felt a sense of connection to the local leaders particularly because they treated them with respect.

*“Yes, she [the chairlady] is and she is very humble and listens to peoples views...our leaders are not such big headed and pompous. They are down to earth and very humble” (FGD - 1701 - 25.08.10)*

In contrast, in a few other communities, local leaders of women’s groups sometimes abused their positions to gain disproportionate access to collective resources mobilised by the groups or by using their position to gain access to other benefits.

*"Chairman of zonal committee has been meeting his girlfriend and saying he is actually at MaiMwana Project meetings. He is bringing MaiMwana Project name into disrepute and causing problems for the group" (OBS - 23 - 52 - 04.10.08)*

## **5.5 Women’s group organisational structures**

### **5.5.1 Types of women’s group organisational structures**

In most communities, structures to organise the women’s groups were developed by the group members at the sub-women’s group, women’s group and area levels. At the sub-women’s group level, many communities established committees to guide the implementation of strategies to address their MCH problems, disciplinary committees to deal with conflicts within groups and social welfare committees to coordinate the generation and distribution of funds amongst group members.

*"Established [committees] for each strategy so that strategies could be implemented simultaneously rather than sequentially. They have a role in collecting information, planning strategies and mobilising resources" (OBS - 11 - 127 - 23.11.06)*

At the women's group level community members formed group committees to guide the groups soon after the women's groups were established.

*“As my colleague has already said, the leaders in different [strategy committees] have the responsibility of taking charge of the outlined activities. Another, good thing that I want to add is that all these [strategy committees] and other committees have a special day that they meet as a group committee. During this group committee meeting, it's where they have a report of all the committees and [strategy committees], the problems that they have encountered and other things that they think are still in need to be implemented in future. During this meeting, it's where the group can plan the way forward in how the group activities will be implemented. This is the ideal time that they resolve other problems rocking the group” (FGD - 2403 - 29.10.10)*

At the area level, committees included zonal committees to organise all the women's groups in a cluster (24 in total), nodal committees to organise all zonal committees in a nodal area (4 in total) and a district committee to organise all nodal committees in the district (1 in total). Three women's group committee members from each women's group were democratically elected onto the zonal committees. Three zonal committee members from each zonal committee were democratically elected onto the nodal committees. Finally, three nodal committee members from each nodal committee were democratically elected onto the district committee. Each committee included a number of office bearers including chairpeople, secretaries, treasures and vice positions as discussed above.

The women's group organisational structures at all levels were linked in a hierarchical network from subgroup committees up to the district committee.

*“We initially started with the main [women's group] committee which resulted in the formation of the [strategy] committees. We delegate responsibilities in the different [strategy] committees such as health, agriculture or bed nets. However, we don't leave the responsibilities to the members of the [strategy] committees alone, no, we all take part in each task of the individual [strategy] committee. In short, within the [women's group] committee, we delegate responsibilities equally so that everyone is seen to be participating. When everything is done, the [women's group] committee sits to discuss and analyse the tasks that were to be done. Analysis of the [strategy] committees is done at this time, where committees present what they have done. Where there is a*

*problem, we look at it together and see what to do...we mobilised these other [strategy] committees knowing that a single [women's group] committee could not manage all these activities alone. As a result, the [strategy] committees are able to mobilise resources/issues from different angles and bring them to the [women's group] committee. From the [women's group] committee, these concerns are referred to the zone facilitator who in turn refers them to the [zonal] committee. The [strategy] committees help ease the pressure of work in the main committee" (FGD - 0206 - 30.07.10)*

In most cases the organisational structures operated independently from other existing community structures but in some cases structures were merged with existing structures which had similar objectives.

*"The Village Health Committee and mobile clinic [strategy committee] share members. Therefore they merged to collaborate on their shared objectives" (OBS - 17 - 68 - 05.10.07)*

#### **5.5.2 Roles and responsibilities of women's group organisational structures**

In most communities the structures were formed to better organise women's group members to address their MCH problems.

*"My addition is that our group activity planning starts from the respective committee or [strategy committee] that has a need to be resolved. The members of this particular committee or [strategy committee] always having identified a need, they call each other and have a primary meeting where they strategize on how they think the activity will be implemented then later on they notify the chairlady on their pre-plans and asks her to call for a group meeting to discuss the issues in details at a group level and re-strategize with the whole group consensus...all the activities of these [strategy committees] operate separately; their respective leaders set the programmes and agendas to be implemented. For instance the health committee set up its own day when they have issues to be outlined to the group, they set up day, they tell us what they think is important at that particular time like clearing the household surrounding by cutting down grass and sweeping, cleaning of all the household utensils to prevent some disease outbreaks, they mobilise us for the group gathering so that we should learn from them, that's part of health committee. Now, when we*

*go to another committee like the dimba committee, they always involve the chief to assist in mobilizing the general community by making public announcements to the selected days for us to go and work in the garden. That's how the committees are involved in organizing and implementing the group activities" (FGD - 2403 - 29.10.10)*

The other key roles of the structures were to resolve conflicts between community members, encourage community members, from within the same community and from different communities, to come together and collaborate in MCH activities and to delegate responsibilities amongst women's group members.

*"I think after sitting down and assessing the activities that they were doing, they knew that it was difficult to do all the activities through their [group] committee. As such they thought of forming [strategy] committees to delegate work that would ensure that objectives are achieved. Through the various committees they thought that they would easily reach out to various activities that they could plan. This is why I think they formed these committees so that the main executive [group committee] should be able to delegate work to other people" (FGD - 2301 - 03.09.10)*

Another key role was to gradually take over the responsibility, from the ZFs and FTOs, to supervise and manage women's groups and committees lower in the hierarchy, to carry out their activities.

*"1503 disbanded and handed a letter over to zonal committee. The committee followed up with the group, their committee and the VH. They accepted the resignation and recommended that people still interested in groups should join 1505. The group had received inputs from Total Land Care so the committee liaised on behalf of the group with Total Land Care and got agreement that the group could repay as individuals rather than as a MaiMwana women's group" (OBS - 23 - 54 - 04.10.08)*

The structures also coordinated the implementation of MCH strategies. For example, they divided up the necessary activities to implement their MCH strategies and delegated them to subgroup committees to take them forwards on behalf of the groups. They were also involved in guiding the implementation of strategies by these individual communities or, through area level committees, guided the joint implementation by several communities.

*“The zone committee serves people in the sense that when the people get things wrongly done; the committee goes there to give advice and instructions on how to get the activity done correctly. It directs women’s groups’ activities” (FGD - 2301 - 03.09.10)*

A key component of guiding strategy implementation was building the capacities of women’s group members to implement the strategies effectively. Committees were responsible for building these capacities in health and other technical aspects related to particular strategies.

*"Nodal committee at Waliranji is showing really strong organisational skills. It is leading and taking control of issues. It will provide business management training to groups to ensure that they manage their loans more effectively" (OBS - 27 - 167 - 21.04.10)*

Another role fulfilled by the structures was to liaise with and lobby for support from stakeholders within the communities, and externally.

*“The agriculture committee for instance, we can go to the Agriculture office. Suppose we have an issue that require assistance from the agriculture office, we consult the zone facilitator who in turn refers it to the centre and from there it may be referred to the agriculture office” (FGD - 0206 - 30.07.10)*

This role often brought women’s group organisational structures into contact with representatives from the statutory sector including the Ministry of Health.

*“Clinics not running because Mchinji District Hospital says they don’t have transport. Zonal committee met with representative from local health facility and were referred to Mchinji District Hospital. They went to resolve the issue by speaking to the Matron and District Health Officer, etc" (OBS - 27 - 179 - 04.05.10)*

Committees also had roles and responsibilities in mobilising collective resources to help address MCH issues.

*“We have set up a lot of committees and task forces [strategy committees] to facilitate different mobilisations, they are skilled in liaising and lobbying, that’s why we are achieving a lot” (FGD - 1506 - 22.10.10)*

They often kept these resources safe on behalf of the women's group members and, where necessary, maintained them in good working order.

*"The bicycle ambulance is coordinated by the group's executive committee [group committee] of the chairlady, secretary and treasurer. All those who need the bicycle ambulance go through these people who authorize its use. After use, we make sure that the bicycle ambulance is returned in order. In case of a breakdown, we sit to assess the damage and repair it using the money that we have with the treasurer" (FGD - 2301 - 03.09.09)*

They also helped to ensure resources were fairly and equally distributed to those in need.

*"There are three people in the bed nets committee. These are the people who are responsible for distribution of nets when they are available. When the nets are available, these people summon us as a group in the presence of the chief. They tell us about the availability of the nets and tell us that these nets should be distributed to mothers with young children and expectant mothers. These women need to sleep under nets. These three people are mandated to see to it that the nets are fairly and freely distributed. The chief finally appreciates the effort by this committee to facilitate these nets. Thanking the committee for distributing the nets so that mothers and children are safe from mosquitoes as they bring about malaria...to young children" (FGD - 0206 - 30.07.10)*

At the area level the structures coordinated the development of higher level proposals and lobbying for resources.

*"Zonal committee in zone 40 met with shadow Member of Parliament (MP). Shadow MP gave them MK20,000 which the committee then shared equally amongst its groups. The committee was able to lobby on a higher level and able to make sure resources were equally distributed" (OBS - 26 - 56 - 23.02.09)*

Furthermore, at the district level the committee had a specific role in managing the district women's group bank account. The account was established, in the name of the women's groups, after a donation of funds by a UK-based organisation. The district committee members were signatories on the account and periodically considered requests for loans, from women's groups in the district, to fund activities to address MCH problems.

"The central committee came together to consider a group account. They made all decisions and instituted their own rules...the FTOs simply gave advice where it was needed. They decided all criteria for the fund: who would be funded; how much funding people could get; and how much interest would be paid on loans" (OBS - 26 - 54 - 20.02.09)

The committees at all levels also monitored and evaluated the implementation of the strategies. In some cases they 'policed' and visited community members to check that the strategies were being implemented appropriately.

*"Now, this committee which you have, the health committee which has three people ensures that people have cleared their surroundings; there's a pit latrine, there is a cloth drying line or plates drying rank, just like in the development committee, bicycle ambulance committee, about the dimba cultivation as well as the home based care" (FGD - 0206 - 30.07.10)*

Finally, they also had a role in gathering and sharing information down, from organisations and community members outside the communities to the community members, and up, from the community members to individuals, groups and organisations outside the communities.

*"I am one of the group members of the zone committee. From the [group] committee, we sit at the zone committee and analyse the concerns. From there, the facilitator directs the concerns to the [nodal office] at Kamwendo where a further discussion or analysis is done. From that level, feedback is given to us to see how we have been assisted on our different concerns" (FGD - 0206 - 30.07.10)*

In contrast in some other communities, the committees failed to organise women's group members to implement strategies to address MCH problems.

*"Chickens at 1704. All the chickens died because they had not received a vaccination. The group was not prepared and lacked the technical skills but more importantly they lacked an active committee to take things forwards effectively" (OBS - 21 - 18 - 25.04.08)*

Furthermore, they failed to help members to communicate with community members outside the groups.



*“There was no any mechanism that was set aside so that the other community members should get some information from us [the group committee]. Whatever we were discussing was on dealt on the group level and not beyond” (FGD - 1006 - 30.10.10)*

### **5.5.3 Characteristics of organisational structures built in communities**

In many communities the committees were cohesive and united with good relationships between members.

*“Just as we have explained, because we [the group committee] are united and work together everybody does what we are asked to do in order to live health lives. We encourage each other to work together because unity is strength” (FGD - 2301 - 03.09.10)*

Indeed, in these communities the committee members in these structures respected each other, were happy to cooperate and engaged in few conflicts.

*“Even though I am a non-member but I see that these people actually work in unison as a committee of course there might be dissenting views and opinions sometimes; that is normal where there are people” (FGD - 2301 - 03.09.10)*

Committees were also generally run in a democratic and inclusive manner which enabled all members of the structures to share their views and opinions and participate in decision-making.

*“We instill a spirit of understanding amongst us and accommodating each others views. When there are dissenting views, we sit down and amicably come to a common understanding. In this way, we ably manage our committee” (FGD - 0206 - 30.07.10)*

Committees rarely made decisions without consulting and involving other community members. They sought to represent the interests and address the needs of all community members. In this way they did not usually work for their own self-interest but rather for the benefit of the entire community.

*“All the activities that are being done in these committees are really representing the whole community...really the whole community is being represented with the activities that we are doing” (FGD - 2905 - 18.10.10)*

Furthermore, the committees also had a confident, independent and self-reliant nature.

*“This committee does not depend on outside assistance. If for example we don’t have money to run the committee, we do piece works. After doing the piece work, we buy fertilizer to apply to the vegetables. We are self-reliant; we don’t depend or rely on help from outside us. We grow our own crops e.g. vegetables, harvest and sell them to see what next we can do with the money. When we have enough money, we plan how to use the money. We may decide to put the money on a revolving loan scheme within the group so as to multiply the money further” (FGD - 0206 - 30.07.10)*

Finally, the majority of committees understood their distinct roles and responsibilities and how they were distinct from other structures at the same and other levels.

In contrast, in a few other communities, the committees were working in the specific interest of the committee members and neglecting the needs of the collective. Furthermore, they were not cohesive or unified and were characterised by a lack of sharing and cooperation which meant they were often in conflict with each other.

*“I think this committee is lacking love and unity in taking part in MCH activities. If love is there in this committee, they could easily open up to each and everyone, they could easily share knowledge and skills so that they can develop the committees. They could easily assist each other in having healthy life. If they lack unity, they keep on pointing fingers on each other but nothing will be achieved in health” (FGD - 2508 - 06.09.10)*

It also meant that in these communities the organisational structures were generally inactive and disorganised.

*“I should just stress on the lack unity and organisation. There is no unity and organisation in our committee, so whatever we might think is important to contribute to the group will deem useless, as they will not respect my contribution. Even if I was a member, I would achieve nothing as there is no unity and organisation...we should change the picture of the group; everything should be new in this group. This will bring unity and organisation. If unity and organisation is restored, it will bring confidence of people in joining the group. Those who dumped the group will be coming back (FGD - 2508 - 06.09.10)*

This lack of cohesion was reinforced by the fact that the members of these committees lacked a clear understanding of the roles and responsibilities of their structures.

"[Strategy committees] arise quite organically. There is little specific discussion about roles and responsibilities - these are worked out organically but this may lead to them not being clear of what they are doing" (OBS - 18 - 81 - 05.11.07)

## **5.6 Resource mobilisation by women's group members**

### **5.6.1 Approaches to mobilise resources**

In many communities women's group members directly and indirectly mobilised the resources necessary to implement their MCH strategies.

"Bed nets were identified as a strategy. But they also identified that they were too expensive to buy so they identified a strategy to grow things in garden and sell them to raise money which could then be used to buy nets" (OBS - 11 - 115 - 22.11.06)

In some cases resources were mobilised exclusively from the community members where women's groups were operating through: donations and contributions of funds and other resources, generation of funds by carrying out paid piecework for other community members and generation of funds by engaging in small scale businesses.

*"Yes, he knows. The [land for the] dimba that we have was provided by the village headman himself after we had failed to secure land for the dimba. We consulted the chief who willingly gave us a piece of land for the dimba. So, he knows everything about the dimba" (FGD - 2301 - 03.09.10)*

In other cases resources were mobilised outside communities in which women's groups were operating from: financial sector organisations such as banks and lending institutions, non-governmental sector organisations such as NGOs and CBOs and governmental sector organisations such as ministry and government departments.

*"We have the working partnership of the health workers and the community development facilitator of this area, Mr. Chunga, who gives us advices on how we can explore some links with other organisations...the other organisation that we are working together is Total Land Care, they provided us with seedlings for our forest, and*

*later on they donated a borehole so that we should be having enough water for the forest irrigation and safe drinking water. They provided us with modern slab toilets, which when the toilet deposits are decomposed, they can be used as mature in our gardens” (FGD - 3603 - 07.10.10)*

When resources were mobilised from outside the community the women’s group members did this through: writing solicited and unsolicited proposals for funds, approaching organisations and lobbying for financial and other resources and organisations approaching the members and offering financial and other resources.

*“Lubaini wrote a proposal to PeaceCorps to help build a clinic” (OBS - 17 - 20 - 26.09.07)*

Finally, in still other cases the members mobilised resources from both within and outside their communities.

*“Yes, I want to comment on the protected well. When we lobbied for this well, the funders sent us contractors to construct it, now at this time there were a lot of local resources that we were asked to mobilise like sand, bricks and stones. We agreed on our group that we need to work together as a group to mobilise all the resources for the well to be constructed. We did it and it happened” (FGD - 1506 - 22.10.10)*

### **5.6.2 Types of resources mobilised**

In most communities the women’s group members mobilised resources that were new in their communities. However, they also succeeded in negotiating and opening up access to resources that already existed but had been inaccessible as they had been mobilised for other purposes.

*"There is an existing bicycle ambulance in the community - used by home-based-care group. Members of women's group sit on the committee and negotiated for its remit to be expanded to include women and children" (OBS - 17 - 56 - 05.10.07)*

In other cases these resources had been inaccessible because they were specifically for the use of only certain individuals or groups within communities, sometimes because they were wrongfully appropriated by these individuals or groups.

*"Akimu zonal committee has retrieved 4 bicycle ambulances from various individuals who had been misusing them...they have placed*

them with respective bicycle ambulance committees. So they have taken resources and made them available to all" (OBS - 25 - 82 - 05.08.09)

Physical resources were the most commonly mobilised resources: agricultural and forestry inputs such as fertilizer, pesticide, seeds and seedlings and equipment such as watering cans, shovels and treadle pumps; protected well and clinic shelter construction materials such as cement, bricks, sand, stones and cement; animals for rearing such as chickens, goats and pigs; home health and hygiene inputs such as ITNs, chlorine, oral rehydration solution, condoms and basic medicines; and other physical resources such as boreholes, beehives, stoves, slab toilets and bicycle ambulances. For example, in 2009, women's groups succeeded in mobilising 40 bicycle ambulances, 247 ITNs and 4936 trees.

Human resources were also sometimes mobilised: community members themselves and extension workers such as HSAs, nurses and clinical officers and agriculture development officers. These human resources provided either labour or technical assistance in to women's group members to implement their strategies to address their MCH issues.

"Committee came back to community with OK from District Health Officer to build clinic. They approached the VH and he agreed it was an important issue. He encouraged collective action to generate the necessary resources...40,000 bricks...many community members involved" (OBS - 18 - 207 - 15.11.07)

Finally, the members also succeeded in mobilising financial resources. For example, in 2009, women's groups managed to raise MK586,485 (£2,200) through IGAs such as group goat and chicken rearing. In the same period they managed to raise MK293,175 (£1,100) through sales of vegetables from group dimba gardens.

In contrast in several other communities the women's group members failed to mobilise or a donor failed to provide the resources they needed.

*"The other thing is about clean and safe drinking water. You can go around my village we don't have a protected well. But initially we have a well that does not dry throughout the year, even our neighboring village of Kumbanga comes to use this well when their wells dries up. Which we are thinking can be upgraded to construct a protected well. We are getting wondering that in other villages, they have boreholes, what is their secret of lobbying? We don't know. They [the donors] asked us to dig a deep well, my men did so, they asked us to mobilise stones, which we actually did, but nothing is happening. It was in 2009*

*when we forwarded this request, and this is 2010, when will we get the well?” (FGD - 3802 - 09.09.10)*

In other cases this happened because the members failed to find a suitable donor while in others they were not able to negotiate access to existing resources in their communities.

*“We had [a meeting] with Kagoli village when we were negotiating about their bicycle ambulance. We went there to discuss modalities on how we could access the bicycle ambulance. We were two women and men who started talking with that group but unfortunately, this never proceeded though we had a spirit of love with our friends” (FGD - 3302 - 24.09.10)*

### **5.6.3 Characteristics of resource mobilisation process**

In most communities the resource mobilisation process was led by the women’s group committees and local leaders. However, in these communities the rest of the group members were generally also involved before a final decision was made.

*“Decisions like these are derived from the seniors, who are the chairman and the chairlady. These are able to give us directions on how we can make our money. How safe can we keep our money or how can we make our money grow? These are the people who decide that to raise our capital; we should invest our money through this borrowing scheme. These people make decisions and bring them to the group where we analyze them to see which ones are productive or not” (FGD - 0206 - 30.07.10)*

As a result, women’s group members were fully engaged in the resource mobilisation process making it a democratic and inclusive process.

*“What I am trying to say is that whatever the fact is, everyone is given the opportunity is contributing any views; we scrutinize them and agree on one thing...everyone was much concerned as they knew that the outcomes will assist the whole community, all people were involved in deciding and organizing the resource mobilisations” (FGD - 1506 - 22.10.10)*

Amongst the group members women usually took the leading role in mobilising resources. This made logical sense to group members as the resources were predominantly for implementing strategies to address the health problems of women and their children.

*“May be it’s with this fact that all the maternal problems primarily affect a woman, so they think it’s their part. Most of the times when a woman is having maternal problems, the husbands are reported to be away on different activities. That’s why women take the lead role in mobilizing MCH resources as they are the ones that are facing the problems” (FGD - 1506 - 22.10.10)*

However, in many communities women also chose to involve men in the mobilisation process as they felt that they could help to make the process more effective.

*“We just started the meetings towards mobilizing resources when we realised that we could not do it by ourselves and decided to invite men” (FGD - 3302 - 24.09.10)*

In contrast in a few other communities the mobilisation process was less democratic or inclusive. Indeed, in some cases resources were given to communities by donors, in a top-down fashion, without any consultation about the needs of the communities or which community members were most in need.

#### **5.6.4 Characteristics of resource distribution process**

In many communities the women’s group members were fully involved in decision-making about the distribution of resources that had been mobilised.

*“In most cases it’s the leaders who take the lead role in these mobilisations, in making decisions in how we will be utilising the resources. But it comes some time that members come up with their suggestions which are taken into considerations on the discussions and see the way forward” (FGD - 1506 - 22.10.10)*

In these communities the members endeavoured to distribute the mobilised resources in a fair, equal and non-discriminatory manner.

*“Yes, let me add on that. Mine is just a compliment on what my friend has said. The bicycle ambulance discriminates no household at all. As long as the household has a problem, or is pressed and they know that there’s an ambulance that we can access, they are free to come, they come and they are assisted accordingly. We are not even worried, we open mindedly give the ambulance” (FGD - 0206 - 30.07.10)*

In particular, they sought to avoid any corruption by distributing the mobilised resources in transparent manner.

*“We negotiated with other people that have a male pig, so that they can keep our pig in the process the mating can occur whereby the pig can bleed. We give one of the piglets to the owner of the male pig as a token of appreciation. Then we share the remaining piglets amongst the group members to start their own household piggery. We left one pig for the group, which continued to bleed; as I am talking it has 6 piglets...there is fair distribution of the piglets. We make sure that those that have not benefitted should get theirs to the next turn. Everyone is satisfied in the way we share the piglets” (FGD - 1506 - 22.10.10)*

To further ensure the fair, equal and uncorrupt distribution of resources the members often developed and signed contracts and constitutions, amongst themselves and with external partners, detailing how the resources would be distributed.

*"ZFs felt that the important thing was that there should be a contract or memorandum of understanding between all relevant stakeholders to ensure there is accountability over bicycle ambulances" (OBS - 19 - 20 - 26.11.07)*

Usually resources were available free of charge to those who needed them. However, in some cases non-members and community members from other communities were asked to pay a small fee which was used to help maintain the resources.

*“Respondent 1: Okay, the arrangement is that this bicycle ambulance is meant to assist several villages surrounding us. As such we do not discriminate anyone. Even if there is a problem from a neighboring village, they come and access this bicycle ambulance. Now, this bicycle ambulance just for the sake that it belongs to the group, to ensure that we are able to maintain it, we charge a little fee. This is done to ensure that if in case of a breakdown, we are able to repair it...*  
*Respondent 2: Yes, let me add on that. Mine is just a compliment on what my friend has said. The bicycle ambulance discriminates no household at all. As long as the household has a problem, or is pressed and they know that there's an ambulance that we can access, they are free to come, they come and they are assisted accordingly. We are not even worried, we open mindedly give the ambulance. However, we ask*



*for a small fee in case there is a breakdown on the ambulance, that fee is used for maintenance” (FGD - 0206 - 30.07.10)*

## **5.7 Women’s groups linking with other people and organisations**

### **5.7.1 Types of links formed with other people and organisations**

In most communities women’s group members succeeded in forming links with other individuals and groups within their communities, and other communities and with organisations outside their communities. New within community links were commonly established with men, often the husbands or partners of group members.

*“There has been change because in the past, men and women never used to be near or together. We feel this is good because we also know about safe motherhood as sometimes even we men take children to postnatal clinics while the woman is doing some other chores at home. This is another change because men could not take children to the hospital in the past as that was considered women’s responsibility” (FGD - 1102 - 21.10.10)*

New within community links were also commonly formed with traditional leaders such as VHs and other individuals in powerful positions.

*“Having seen that the group village headman is such a big and important person and coordinator of everything here we thought of linking our activities with him. Whenever we have fallen short of anything, we report to him for instance. When we need people to discuss some issues with, he has the capacity to mobilise these people for us because as a group we don’t have people. So he helps us mobilise people for us. An example could be given that when health assistants come here to teach us about health issues, we go through the chief who mobilises people for us. Some times when we have no land for a dimba or seasonal cultivation, we also ask for his assistance. We are in a very good partnership” (FGD - 1102 - 21.10.10)*

Finally, new within community links were also formed with other groups working towards related aims and objectives such as village health committees and child, orphan and HIV care groups. Links with these groups were often facilitated by women’s group members who were also members of these other groups.

*“We have also been in working relationship or partnership with the orphan care which is within this village...to link with the orphan care we had to look at the needs that were common to us like the bicycle ambulance to take patients to the hospital so as to improve safe motherhood. After careful consultations, we realised that it was good to establish links with orphan care” (FGD - 1102 - 21.10.10)*

New between community links were commonly formed with women’s groups in other nearby communities, often within the same cluster.

*“We have formed another partnership with the Dikirani women’s group who owns the bicycle ambulance which we share whenever there is a sick person or a woman with any maternal problem to the hospital” (FGD - 2505 - 13.10.10)*

Finally, new links with organisations outside the community were commonly formed with private and public sector institutions operating in Mchinji district.

*“As soon as the women’s group was established, we were discussing the most common health problems of our community like maternal problems. When we identified these problems, we prioritised the first five problems that needed immediate attention and found solutions to these problems. This is why we decided to form these links with others so that we are helped to get rid of these MCH problems through among other things the dimba cultivation, acquisition of bed nets and different counseling skills. This is why we formed links with Partners in Hope [a Lilongwe based private health clinic], the health department, the chief, etc to end the different health problems” (FGD - 1102 - 21.10.10)*

#### **5.7.2 Purpose of links formed with other people and organisations**

In most communities the links were formed to allow women’s group members to gain access to resources or to allow the exchange of resources between the partners. In most cases, these exchanges involved the partners providing loans or donations of financial and other resources to women’s group members.

*“We formed these partnerships with COMSIP and Micro Loan Finance, as we realized that most women in our community are not economically empowered, they lack most basic household essentials, so we discussed that if we can approach these micro finance institutions we will be getting loans which can enable women to start small scale*

*businesses to improve their household welfare and having basic health necessities” (FGD - 2505 - 13.10.10)*

These non-reciprocal exchanges generally took place between organisations outside communities and women’s group members. However, in other cases, they took place between women’s group members in different communities or members of different community groups within the same community.

*“This is evident by the sharing of resources between us. The orphan care group are free to come to us and get anything that they want to use at their place just as we are also free to use resources from the orphan care. We have some activities like meetings or others; we invite them to attend the meeting or such other things showing that we are supportive and communicate well” (FGD - 1102 - 21.10.10)*

In many communities, to enable women’s group members to lobby resources, the links facilitated the writing and submission of joint proposals for new resources.

*"Link to the HSA and PeaceCorps. Together they wrote proposals with women's groups to UNICEF and Ambassadors Fund for TBA training, a bicycle ambulance and health education" (OBS - 17 - 91 - 09.10.07)*

The links also allowed the partners to pool their resources. In this way a larger population was able to access the resources they needed.

*“We formed the partnership with the Dikirani women’s group with the influence of MaiMwana, when we prioritised our needs, about long distances to the health centre, we were enlighten that close to our women’s group, there is another women group which owns a bicycle ambulance, if can talk to them we can be sharing that resource” (FGD - 2505 - 13.10.10)*

Finally, the links enabled members to lobby for resources from donors at district, regional, national and international levels and enabled groups in different communities to lobby together for resources to implement their MCH strategies.

*"Several communities have linked together to request village health committee training" (OBS - 17 - 102 - 12.10.07)*

### 5.7.3 **Characteristics of links formed with other people and organisations**

In most communities the links were collaborations formed and led by the women's group members themselves.

*“One of the procedures was that we sat down to discuss then we invited our partners for a meeting together with the chief where we discussed the possibilities of partnering. This was agreed with our partners and so the partnerships started” (FGD - 1102 - 21.10.10)*

In other communities the links were collaborations initiated by either the women's group members or their partners but where both partners were equally responsible for leading the collaborations.

*“We were sharing the responsibilities of our MCH needs with our partners, for example when we were prioritising our needs about malaria we were doing that in collaboration with the health workers as we were aware and assured that they will supply us with mosquito nets. In the process there was another problem that was cordially identified by the health workers and us about diarrhea in mothers and the under five children, they started providing us with chlorine for water protection” (FGD - 2505 - 13.10.10)*

In these equal collaborations the partners shared power over decision-making.

*“We equally share power. This I am saying on the background that suppose we have some piece work, we do that together with members from the Orphan Care. Not only that, we rely on people's good will to run the Orphan Care, in that case whenever we want to mobilise anything especially food items for the orphanage, we do this together. We go into the village together asking for any assistance from people. This therefore means that we have equal powers” (FGD - 1102 - 21.10.10)*

In both types of collaborations described above, the different partners were clear about their tasks, the resources they shared and their particular responsibilities within the relationships they had formed.

"Brought stakeholders and ZFs and WG members together at nodal level. Discussed problems faced by groups and also strategy lists.

Discussed and agreed roles and responsibilities of groups, MM, and local stakeholders. Then filled in and signed MoUs on the basis of agreed roles and responsibilities" (OBS - 16 - 139 - 18.09.07)

Furthermore, the partners generally communicated clearly, shared information openly and supported each other.

*"I think I should say that we are good at information sharing and communicating to our partners. For instance, once a time, we received a certain lady from Basa village who was looking for guidance in how she can access the loans from the financial institutions, we told her to come on the day that the Loan Facilitation Officer will come to our village and we managed to send messages to the officer to arrange a date so that particular woman can get an assistance" (FGD - 2505 - 13.10.10)*

In contrast in a few other communities the links were initiated by organisations external to the communities. Usually women's group members were only involved tokenistically or informed of decisions made but not involved in the process of making these decisions.

*"We were the receiving end of information in all the partnerships that we had because they would come and tell us more about our health and what we are supposed to do...CADECOM (Catholic Development Commission in Malawi) came here to improve our skills in village savings and loans...this CADECOM gave us skills in saving money on the group every week, this money is kept in a form of shares per capita and after some period, let's say after a month, we can start individual money borrowing which is paid back with 10% interest. If I take K1,000.00, I am supposed to pay back an interest of K100.00. We use this money as a startup capital in our small scale business" (FGD - 2505 - 13.10.10)*

This type of collaboration was characterised by power differentials between the different partners. Generally, the women's group members had less power to make decisions than the other partners. In this way top-down collaborations were formed.

*"As much as the link between the women's group and Partners in Hope is concerned, it is evident that Partners in Hope have more power than us in as far as material or technical assistance is concerned but we are equally strong in our group. This however is not a problem to us*

*because they help us to acquire resources which otherwise we could not have" (FGD - 1102 - 21.10.10)*

This type of collaboration was also more likely to be characterised by a lack of respect for the women's group members from their partners.

*"Workers at Kapiri hospital have refused to give health education in Nthema...they said they were too busy" (OBS - 26 - 32 - 20.02.09)*

Indeed, in some cases this lack of respect went as far as the partners withdrawing from the link without informing or consulting the members. In other words leaving them 'in suspense'.

*"We are almost doing everything here but we would want to request for our partners [Partners in Hope] who have helped us for a great deal of time to remember us by coming here as they used to do so that we keep on being assisted. We would like to request them to come back to us. They have not been coming for close to a year now. We urge them to come to our assistance; they used to help us on many things that we could not manage by ourselves. Thank you" (FGD - 1102 - 21.10.10)*

However, in other cases these 'top-down' collaborations gradually evolved, over time, into true collaborations where the members and their partners equally shared responsibility for leading them.

*"Yes, our minds will open up; we will be able to know how best we can do the things. In most cases people believe that the organisations should be coming to assist us in whatever we want. In so doing our skills will change. These syndromes are changing, we will be able to things on ourselves and the organisations if they are willing they can come to assist us on what is remaining" (FGD - 2508 - 06.09.10)*

## **5.8 Women's group members asking why**

### **5.8.1 Contributing factors to MCH problems identified by asking why**

As stated above in section 5.3.1, in many communities the women's group members succeeded in identifying the underlying socio-environmental risk factors that contributed to their MCH problems. The risk factors most commonly identified were those associated with financial and resource poverty.

*“Having a big number of children at a family was promoting the high levels of poverty in our homes...because the health workers advise pregnant women not to overwork during to prevent some health problems. Now at this time when the woman is pregnant all the household chores and all farming activities rely on the husband who lacks the support of the woman rendering low development to the family and poor health” (FGD - 3603 - 07.10.10)*

A particular resource that members often identified was lacking, was adequate information about MCH problems experienced and solutions that might help to prevent and manage them.

*“I just want to add that sometimes it is lack of proper advice that causes some of the MCH problems. When one receives advice on MCH it is easy to prevent problems like miscarriage and how to prevent malaria...i think it's none other than ignorance and lack of proper advice. Instead of going to the hospital, you would see that women prefer going to the TBA...the main problem is ignorance of what is supposed to happen and negligence of going to the hospital as someone said. At the hospital, the doctors advise women on preventive measures of diseases, now when someone does not go to the hospital; it is difficult to know these instructions” (FGD - 3703 - 16.09.10)*

Members also commonly identified disempowerment, at the hands of other individuals, groups and organisations, as a key contributing factor. For example, that men sometimes prevented women from making decisions about issues that affected their health and the health of their children.

*“If a woman has intensive deliveries the uterus worn out, this is another health problem to women. The only way of reducing this problem is going for family planning at the health facilities. Now with this issue being raised that they are being denied [by men] the access to the family planning methods, we discussed this issue on our group that if woman delivers for up to four times there is no need of taking any other family planning methods, it might have some health impacts. The recommended number of children per women to be practicing family planning is two or three” (FGD - 3603 - 07.10.10)*

Lack of literacy and numeracy was another key contributing factor identified by members as they made useful medical information inaccessible to them.

*“What I want to comment is that this illiteracy, was contributing to the level of our health problems. When we have gone to the hospital to seek medical care whenever we are sick, they write a prescription of the dosage. They write a number of tablets to take either in the morning, afternoon or evening, we were unable to read this which was resulting to wrong taking of the drugs, which was also increasing the level of our health status. The same was applying to children’s vaccines; we could get the same vaccine twice because of failing to read” (FGD - 3603 - 07.10.10)*

Many members also felt that others, particularly professionals, treated them with disrespect. This had potentially the greatest impact on their health when it involved health workers as it resulted in community members choosing not to deliver at the health facilities.

*“Most of what we do involve women going to the hospital unfortunately these women come across hostile situations there and they come back to us as local leaders to report the hostilities. We then report these issues to MaiMwana leaders so that they go and talk to the hospital staff on their verbal aggression to women so that these women do not shun the hospitals” (FGD - 2902 - 05.11.10)*

Finally, social isolation was also commonly identified by members as a key contributing factor. They realised that social isolation meant they were unable to access necessary social support from other individuals, groups and organisations, such as emotional, tangible or informational support.

*“If people do not come together to share knowledge on different things, there is also lack of knowledge. There is nothing a person can learn in isolation. But when people stay together and share ideas, one learns so many things like how to prevent malaria for example. One may also learn what to do to keep her pregnancy to avoid any miscarriages that might have occurred. But when you are alone, in isolation, you cannot learn these things” (FGD - 3703 - 16.09.10)*

In communities that engaged in this deeper exploration of contributing factors the process fed into a wider process of critical reflection. Here after analysing the root causes of their problems they then identified actions to address these causes which subsequently led them to take social and political action to improve MCH in their communities.



*“The base of malaria is poverty...as we were involving ourselves in discussing the causes of malaria, we realized through the group meetings that malaria comes because of mosquito bites. The solution of preventing malaria is sleeping under mosquito nets. We managed to conduct surveillance in our community about the availability and use of mosquito nets, whereby we established that there are a few who have the mosquito nets in their households. We discussed with our [FTO], Mr. Potifala, who managed to liaise with the health workers to source nets for us. When the nets were sourced, we were told to buy them at a small amount. After this we realized that there is less effects and attacks of malaria in our community as many mothers and children are sleeping under mosquito nets” (FGD - 3603 - 07.10.10)*

This process of identifying socio-environmental contributing factors and critical reflection took a ‘long time’. It did not happen immediately, at the start of the intervention, but in most cases took a couple of years to reach a point where the women’s group members became aware of the root causes of their ill health and took action to address them.

*“For this adult literacy school to be established it took us a long period as we involved ourselves in the process of discussion on our group, identifying the problems and strategizing on them. If I can recall well, this organisation of MaiMwana came into our community in 2003, so for the group to be established, organise ourselves, starting strategizing up to the extent of realizing that illiteracy is contributing to our health, it was a long period” (FGD - 3603 - 07.10.10)*

In contrast, in a large number of other communities women’s group members had not yet reached a point of identifying these root causes of their MCH problems and of taking action to address them.

### **5.8.2 Characteristics of the process of asking why**

In most communities the women’s group members were fully involved in the process analysing the socio-environmental risk factors and democratically engaged in discussing and sharing their ideas and opinions. Generally, they did this to ensure that the actual problem affecting community members was addressed.

*“All the decisions that we were making [about contributing factors], were being done at the group level. We were giving freedom to group members to contribute whatever they think is important and we had to*

*debate as a group for the best option. This was important as we were targeting the whole community” (FGD - 3603 - 07.10.10)*

## **5.9 Equitable relationships of women’s groups with the external agent**

### **5.9.1 Functions of the relationships with the external agent**

MaiMwana Project, through the ZFs, FTOs and SFTO, is the external agent of the women’s group intervention. The key function of the relationship of the external agents with women’s group members was to build their capacities, through facilitation of groups and formal and informal training, organise and mobilise them to take control of the determinants of their health.

*“MaiMwana Project will not issue any handouts for the activities to be operating, there are a lot of organisations that manage their activities and programs by giving out handouts, but MaiMwana Project has a different strategy and approach to its activity implementation. MaiMwana Project empowers the community to know and identify their own health problems, they should establish why the problems are there, how they can prevent those problems by making their own community initiatives; they should be using the group as the main tool and all that is available locally” (FGD - 2403 - 29.10.10)*

The external agent built the capacities of community members to participate in women’s groups by forming groups, encouraging community members to attend and facilitating the meetings.

*“The group has helped in bringing people together, learning to be tolerant towards issues as well as changing women’s attitudes to understand issues in their families as well as men being forward-thinking on mistakes. The external agent helped us to unite and work as a group” (FGD - 2902 - 05.11.10)*

The external agent also built the capacities of women’s group members to assess their MCH problems, the factors that contribute to these problems, solutions to prevent and manage these problems and strategies to implement these solutions in practice.

*“The knowledge that we got since the the women’s group came is the training and awareness that we got from the MaiMwana facilitator because in the first place we were not knowledgeable of the problems that were within us. We hardly knew our problems and how to deal with them. But this awareness came through training that we got*

*from the facilitator. Therefore, we accepted that and we have been discussing that in the village through the women's group meetings" (FGD - 2304 - 14.09.10)*

The external agent also built the capacities of some women's group members to become local leaders to provide direction to the groups and their communities to address their MCH problems. This included the ZFs supervising the local leaders and organisational structures in women's groups to ensure they carried out their roles and responsibilities effectively.

The external agent also built the capacities of women's group members to mobilise the resources necessary to address the MCH problems they were facing. In some cases this took the form of brokering resources for communities from external organisations. Here the role of MaiMwana Project was to make contact and link the external organisations to the groups. However, MaiMwana ensured that the responsibility for mobilising the resources remained in the hands of the communities.

*"Mainly, this bicycle ambulance was a solution of transport of pregnant women to the hospital. We wanted to save the lives of mothers that are ready for delivery by taking them in time to the hospital in time. Since, it was amongst our prioritised needs, MaiMwana Project made an initiative to...lobby it for us from another organisation which I can't know its name...in fact we were writing and submitting our monthly reports through the facilitator. Whenever the facilitator comes, we were telling her of all our needs. Now MaiMwana Project, by following our reports, they made an initiative to liaise with another organisation which provided the bicycle ambulance. I should stress here, that MaiMwana Project didn't gave us a bicycle ambulance. It only lobbied for us." (FGD - 1506 - 22.10.10)*

The external agent also built the capacities of women's group members to link with other individuals, groups and organisations. In some cases, particularly with organisations working at the district, regional, national and international level, the external agent made the first contact with the organisations on behalf of the members to explore whether they might be interested in partnering with them to address their MCH issues.

*"The project helps us a lot because they first taught us about malaria and abortions and still births. It is also MaiMwana Project that helped us a great deal to link with these other organisations. It is through MaiMwana Project that we were introduced and knew other organisations" (FGD - 2902 - 05.11.10)*

As well as building the capacities presented above, in most communities, the external agent also aimed to hand over responsibility for managing the women's groups themselves. In particular, over time, the ZFs graduated from being primarily concerned with facilitating the groups to supervising women's group members to do this themselves. As a result, the external agent gradually handed over the responsibility for facilitating and implementing the intervention to the women's group members.

*"I want to add that apart from the main facilitator who was chosen by MaiMwana Project, who comes to train us and be part of our group meetings, to impart us with knowledge and awareness, we have another opportunity that we have our own group facilitators who have the knowledge and skills in upholding our mother and child needs within the society" (FGD - 0205 - 03.11.10)*

Eventually, the external agent withdrew from the communities once adequate capacity had been built and responsibilities handed over.

*"WG strategy is to support women's groups to advocate for themselves rather than MaiMwana Project doing it for them" (OBS - 6 - 19 - 27.08.05)*

The corner stones to this 'exit strategy' were: the selection and training of VFs to take over the responsibility of facilitating the groups, training and encouragement of women's group members to spread knowledge and support to other community members through peer-to-peer interactions and the establishment of a hierarchical system of committees to coordinate the work of the women's groups. In relation to VFs, three volunteers were elected by women's group members and trained in facilitation and leadership skills and provided with the necessary tools and resources to facilitate the women's groups.

*"Ah! When MaiMwana Project came in this village, it taught us so many things that we learnt. From that stage of learning, we came to another stage where we elected village facilitators who would teach other women in the village. We got the knowledge to choose facilitators within the village to work on MCH activities...we have three group facilitators that were selected within the group and they went to be trained on the skills and abilities of educating and bringing awareness to the community and organise group and community meetings" (FGD - 2902 - 05.11.10)*

In relation to, peer-to-peer interactions the women's group members were trained and encouraged to share support with non-members. This support included advice and information about what they had discussed and learnt during the meetings, emotional support and tangible assistance.

*“There were trainings on the capacity building of our group members in how they can train, teach and educate other group members and non group members in safe motherhood activities” (FGD - 0205 - 03.11.10)*

In contrast in some other communities, the external agent failed to adequately build the capacities of women's group members to organise and mobilise themselves to take control of the determinants of MCH.

*“Facilitator: Alright, were the leaders managing to organise activities that could pool some human and any other resources within the community?”*

*Respondent: This was very difficult as we were lacking direction from the facilitator who failed to give us capacities to sustain our group, so that's why everything came to a standstill” (FGD - 1006 - 30.10.10)*

In particular in these communities, the external agent failed to build the capacities of women's group members to mobilise the resources they needed.

*“When people heard of MaiMwana Project, expectations were high that there would be hand outs but a year down the line without any tangible handouts, they concluded that the organisation was useless. A few of us who remained thought that if anything, we would get results later. We tried as much as possible to stick by but we gradually failed too” (FGD - 3302 - 24.09.10)*

They also failed to provide adequate supervision and support to women's group members. In particular to local leaders and organisational structures.

*“The main factor that is contributing much to the failure of the chairlady is using her capacity to organise meetings so that the group could be meeting regularly and discuss the important issues. But all this failure is there with the influence of the facilitator who is failing to come to meet with the chair on the matters of this group. She is failing*

*to guide the chair on how to take care of the group, so, its very easier for the chairlady to go wrong as she don't have an advisor. She lacks direction" (FGD - 1006 - 30.10.10)*

Finally, as well as failing to build certain capacities the external agent also failed to hand over the responsibility for managing the intervention to the women's group members themselves. This generally happened where the external agent failed to implement an adequate 'exit strategy' resulting in it exiting the communities before adequate capacity had been built and responsibilities handed over.

*"Group at Nauti complained that ZF left everything to them rather than putting her own views into the discussion. They felt that ZF should also share her views rather than simply presenting topic and getting them to discuss. They don't feel properly guided. Starting to hand over responsibility before adequate capacity has been built" (OBS - 10 - 45 - 08.05.06)*

#### **5.9.2 Characteristics of the relationships with the external agent**

In many communities the relationship of the external agent with women's group members was cooperative and egalitarian so that both shared power in decision-making.

*"At first before we were taught anything, it was the project that had more powers than us. But after being taught and known what they taught us, we now have equal powers with the project where we can easily say no to a situation which we consider not in order" (FGD - 2902 - 05.11.10)*

In these communities the external agent was not considered to have superior knowledge to the women's group members. Instead, both were considered to have different but equally useful knowledge and skills to bring to the relationship.

*"On this issue there are two categories of problems that always affect us, there are some problems that we are able to manage them at the group level but there are other problems that are beyond our control, we can know why they are happening, but the only way out of those problems needs a good collaboration with the external agents to give us a good support and expertise" (FGD - 2403 - 29.10.10)*

In addition, both partners had a clear understanding of their roles and responsibilities in the relationship.

*“Most of our responsibilities and duties are shared after we have discussed on our group, once we have agreed to work on the dimba, we share responsibilities amongst ourselves, but it is difficult to share the responsibility with the external agent directly, though we can say that partly we do share the responsibility in managing mother and child activities as we are the implementers at the ground while MaiMwana imparts the knowledge and skills in us. We teach and train each other on our group in how we are supposed to the things” (FGD - 0205 - 03.11.10)*

In contrast, in a few other communities the relationship between the external agent and the women’s group members was unequal. In these cases the external agent took a directive rather than guiding approach to helping them to address their MCH issues.

*“Our involvement was just making sure that we are implementing what they are telling us to do...as already mentioned, the external agent is the main party that gives out things that we can see with our eyes and we use them in different implementations, and it shares us with knowledge that we put into use, once we are implementing all the techniques that the external agent has direct us to do in MCH” (FGD - 0205 - 03.11.10)*

As a result, members sensed that the external agent had more power in making decisions than they did and thus felt dependent on it.

*“MaiMwana Project has more powers than the group because we learn from them. We did not know anything by ourselves. They know more than us” (FGD - 2902 - 05.11.10)*

## **5.10 Control of women’s group members over programme management**

### **5.10.1 Aspects of the programme managed women’s group members**

In many communities the women’s group intervention programme was managed by women’s group members themselves.

*“This responsibility of managing the activities falls under the women’s group because we live with the people here in the village. We have the responsibility to see to it that women attend ante natal clinics and in good time” (FGD - 2902 - 05.11.10)*

In some cases control of the programme rested with the women's group members to such an extent that MaiMwana Project had become dependent on them rather than vice versa.

*"MaiMwana Project relies on us because by itself it cannot achieve its objectives in the community; but through us" (FGD - 2902 - 05.11.10)*

In these communities the women's group members were involved in managing all aspects of the programme: forming groups, making decisions about group logistics such as meeting time and location, making decisions about group membership and forming committees and electing leaders.

"Discussed constitution and came up with own rules and regulations. They, themselves, decided who should be included and roles and responsibilities of committee members. Also selection of committee, done by group, proposal and acceptance through voting. Voting involved a blind ballot. Top-voted person for each post was the committee member and the second voted person was the vice for that post" (OBS - 7 - 118 - 10.10.05)

As described above, this also involved members gradually taking on more responsibility for facilitating the women's groups.

"Between monthly meetings women in many groups in Waliranji are meeting without ZFs and conducting meetings. In these meetings they are discussing issues - general MCH issues and WG logistics, social issues, etc" (OBS - 6 - 85 - 05.06.07)

They were also involved managing the strategies developed through the programme such as identifying: MCH problems, factors that contribute to these problems, solutions to prevent and manage these problems and contributing factors and locally feasible strategies to implement these solutions in practice.

*"When we meet as she has said, we also set a day for the next meeting. We delegate duties to various groups to be reported on the next day of the meeting. Without such planning, it would be difficult for us to do the works that we intend to do like cooking or washing clothes for the aged or vulnerable people" (FGD - 1205 - 25.10.10)*

They were also involved in mobilising and securing collective resources, recording and documenting progress on strategies, managing finances, carrying out activities to implement



the strategies in practice, solving problems that arose during the strategy implementation process, monitoring and reporting and communicating progress on strategies to other stakeholders.

"Communities signed a memorandum of understanding / contract between partners and donors (UNFPA / District Health Office / MaiMwana / women's group). The contract hands over responsibility for management of the bicycle ambulance to the community. They are being given responsibility for programme management - monitoring of strategy, ownership, management, etc" (OBS - 19 - 62 - 05.12.07)

Finally, members were also involved in evaluating the strategies and using this information to plan and implement changes to improve them in the future.

*"We always sit down as a group and see all the activities that were planned, how they have been implemented, have we managed to reach the expected results? Imagine, we planned to involve in the income generating activity, then we have some money with us, we ask ourselves, is this enough as per our requirement, and then we discuss as a group in how we are going to utilise the money. It's like re-strategizing on the way forward after evaluating our activity implementation. We have another group activity evaluation system whereby we all sit down and do a simple vote to a particular activity on whether it was well implemented or not, so we give out points to each activity" (FGD - 2403 - 29.10.10)*

Although in these communities the women's group members took the lead in managing the programme they had the confidence to call for assistance from the external agent and others in times of need. However, these others were only invited to build specific capacities that the members identified were lacking. They were not called on to do things for the members.

"Change in role of ZF in phase 3. Far less formal and more about checking progress and trouble shooting. She feels she has handed over responsibility to the group...although she still advises and troubleshoots but the group makes their own decisions. They are not being led anymore and they are being supported to go forwards themselves" (OBS - 17 - 134 - 18.10.07)

In contrast, in several other communities the women's group members failed to take control of the programme. For example, they were not able to effectively implement their strategies.

"Bicycle ambulance in zone 11 has not yet carried anyone to hospital. Some strategies, even when they have all necessary resources, are failing to be implemented effectively because the communities are failing to take control over them adequately" (OBS - 21 - 16 - 22.04.08)

#### **5.10.2 Characteristics of the programme management approach taken women's group members**

In most communities the women's group members took responsibility for managing the programme but also established mechanisms to maintain representative inputs from other stakeholders. This included: involving all relevant programme stakeholders from within and outside the communities in discussions about programme management, ensuring that these discussions took place frequently and providing feedback to stakeholders about decisions made.

*"There is proper coordination between the group chairlady and other leaders, once there is a need to meet and discuss, she calls for a meeting whereby the issue in need is discussed and make sure that a solution is reached. Sometimes, we may meet just only discuss about the finance mobilisation, if there is a piece work us to do, we agree and do it" (FGD - 2403 - 29.10.10)*

This meant that the members also managed the programme in a democratic and participatory manner.

*"We make decisions in liaising with all the [strategy committees] that we have in our group, we make sure that all the committee members have contributed their suggestions in formulating any decisions" (FGD - 2403 - 29.10.10)*

Indeed, although the programme management was often led by local leaders or committees in women's groups, these individuals and groups also ensured that other women's group members were also involved in decision-making.

*"We are about 5 or 8 to 10 of us to meet and make our programs. There we all decide on logistics of how we can implement a certain program. So the chairman would certainly start a topic on whether we should go to the dimba or we need money to accomplish a certain activity as such we need to do some piece work. Programs or activities are thus initiated by any one individual and are fully deliberated at the group and reach a common understanding. If it were some piece work for*

*example, we send a representative from the group to go to the garden to inspect the work and agree on the contract fees and report this to the rest of the group. As a group we set a day to go there to do the piece work after having agreed on the terms together. Most often it is men who go for such errands of job inspections whether two or three according to the availability of members as we are very few now, most members have since left” (FGD - 1205 - 25.10.10)*

To achieve this members facilitated free and inclusive discussions and encouraged united decision-making.

*“We really have the freedom in all the activities that we are managing. As already mentioned by someone in the earlier contributions, we have said that once the committees suggest or make any decisions, they make sure that their suggestions are forwarded to the group for everyone’s contribution or amendment, if there is something that we feel there is need of changing, we have that ability to do so. The committees are not powerful or they are not above the group itself. The group is the last resolution to all the decisions that we make, each and every member has the ability to freely participate and contribute in how we could be managing our activities” (FGD - 2403 - 29.10.10)*

Finally, members managed the programme in a transparent and accountable manner.

*“The first point is that we have the group treasure that takes care of all the group assets, whenever we have raised some funds through piece works, we forward the money to the group treasure to take care of it. Now, in managing our group finances, we have a group secret, doing things openly on the group level, it is whereby we always have the group consensus in how the funds should be utilised, we should always work together in managing the funds. We set up a special task force [strategy committee] that monitors the funds administration in our group. We make sure that this task force [strategy committee] have the updated reports in how the funds have been utilised. They come to the group to tell the entire group in how the money has been utilised as per stipulated plans and needs. They work to ensure accountability and transparency in funds utilization; everyone should know how the funds were used. The funds are a group treasure, so, everyone has the responsibility of getting information in how it has been used. They always update us in how much has been used per activity and how much is remaining” (FGD - 2403 - 29.10.10)*

## **5.11 Summary**

Table 5a (page 227) presents a summary of how women's group members, in many communities, organised and mobilised themselves to take action to improve MCH.

The findings reveal that in most communities, individuals, motivated by the MCH issues facing them, came together with others to begin to address these problems. As they started to come together, these individuals were able to collaboratively and democratically explore their common mother and child health concerns and develop solutions to address them. In this way, individual community members were able to organise themselves into small mutual groups around their common concerns and motivations. The findings show that these small mutual groups were informally organised but provided the forum for community members to come together, learn from each other and develop their skills. The groups were organised democratically which enabled community members to participate actively in discussions. These discussions generally focussed on MCH issues and involved community members freely and openly sharing their experiences and opinions.

Once organised into small mutual groups, the findings reveal that in most communities, natural leaders started to emerge and their roles and positions were formalised. At the same time the groups also developed committees and other structures, at village and area level, to manage the leaders and group members. In this way, the small informal groups became more organised, directed and structured into community organisations. The findings show that these community organisations had established structures, functional leadership, the means to communicate with other individuals, groups and organisations and the ability to organise their members to take action. The leaders and structures developed were generally respectful of, and dedicated and committed to, the community members and provided a wide range of support for them to socialise and engage in action to address their broader MCH concerns.

The findings reveal that in most communities, the community organisations enabled the community members to begin to identify, lobby and access the wide range of resources they needed and also to look beyond themselves to other individuals, groups and organisations with similar goals with whom they could form partnerships to take action on MCH. In this way, the community organisations became more organised into local and area level partnerships. The findings show that these partnerships were mature and generally involved equality between partners in decision-making, roles and responsibilities. The partnerships ensured, not only that limited resources were pooled and thus more accessible, but also that they were subsequently distributed equally within the communities to those in need. They also ensured greater support, coordination and participation in MCH issues.

Once formed into partnerships, the findings reveal that in many communities, community members had the opportunity and support to actively and critically analyse the broader social

and environmental causes of their MCH problems and identify actions to address these. In this way, the partnerships allowed community members to take collective social and political action to address their concerns.

Thus, the findings reveal that community members in most communities progressed from a position of individual concern and action about MCH issues, through increasing organised and mobilised groupings, to a point where they were collectively involved with redressing the deeper underlying causes of these issues. The findings also reveal that the capacities and responsibilities for this increasing fomentation were gradually developed in the community members by MaiMwana Project staff. The findings reveal that in most communities, the result was community members taking control of their MCH and acting in a collaborative and organised manner to take social and political action to achieve health equality.

Furthermore, table 5b (page 228) presents a summary of how women's group members in some communities failed to organise and mobilise themselves to take action to improve MCH.

The findings reveal that in some communities, individuals failed to come together in large numbers with others to begin to address their MCH problems. Furthermore, those individuals that did start to come together generally came from the same groups within communities. As a result, with a narrower experience base, they failed to identify the wide range of MCH problems facing them. In this way, individual community members were not able to organise themselves effectively into small mutual groups around their common concerns and motivations. The findings show that the small mutual groups formed were not very organised and thus did not provide an adequate forum for community members to effectively come together, learn from each other and develop their skills.

The findings reveal that in some communities, although leaders did emerge from the small mutual groups their roles and positions were not formalised and they did not act in the best interests of the rest of the community members. At the same time the groups also managed to develop committees and other structures, at village and area level, but these lacked the focus to effectively manage the leaders and group members. In this way, the small informal groups did not become much more organised, directed and structured and thus failed to form structured community organisations. The findings show that the community organisations that were formed did not have very established structures, functional leadership, the means to communicate with other individuals, groups and organisations or the ability to organise their members to take action. The leaders and structures developed were not generally respectful of, or dedicated and committed to, the community members and thus did not provide the support necessary for them to socialise and engage effectively in action to address their broader MCH concerns.

The findings reveal that in some communities, the community organisations were not able to effectively support community members to identify, lobby and access the wide range of resources they needed. The community organisations were also not able to link with other individuals, groups and organisations with similar goals. In this way, the community organisations were not able to effectively further organise themselves into partnerships with others. The findings show that where partnerships were formed they were generally top-down with the community members being led by the other partner who did not fully respect them. The partnerships thus failed to ensure that any resources accessed were distributed equally within the communities to those in need.

Once formed into partnerships, the findings reveal that in some communities, community members were unable to critically analyse the broader social and environmental causes of their MCH problems and identify actions to address these. In this way, the partnerships were not able to catalyse community members to take collective social and political action to address their concerns.

Thus, the findings reveal that in some communities the community members failed to progress from a position of individual concern and action about MCH issues to a point where they were collectively involved with redressing the deeper underlying causes of these issues. This progress was hindered as the community members were unable to form increasingly organised and mobilised groupings. The findings also reveal that this was, at least in part, because the capacities and responsibilities for this increasing fomentation were not developed effectively in the community members by MaiMwana Project staff. As a result, community members were not able to take control of their MCH and act in a collaborative and organised manner to take social and political action to achieve health equality.

*Table 5a: Summary of how women's group members in many communities organised and mobilised themselves to take action to improve MCH*

<p>Community members come together with others in similar circumstances by participating in women's groups:</p> <ul style="list-style-type: none"> <li>• In large and heterogeneous numbers.</li> <li>• Actively and democratically.</li> </ul>
<p>Community members identify common concerns and solutions by assessing problems in women's groups:</p> <ul style="list-style-type: none"> <li>• and identifying of a wide range of MCH problems, prioritising the MCH problems considered to be most important, identifying the factors that contribute to the MCH problems, identifying a wide range of solutions to the MCH problems and identifying a wide range of strategies to implement the solutions in practice.</li> <li>• by freely and openly share personal experiences and opinions, including the views and opinions of a number of different groups and equally and democratically considered the views of all participants.</li> </ul>
<p>Community members receive direction and structure from local leaders developed in women's groups:</p> <ul style="list-style-type: none"> <li>• including VFs, ub-group, group and area level committee office bearers and vice-office bearers such as chairpeople, secretaries and treasurers and women's group members themselves.</li> <li>• who provide strategic direction and coordination for the women's groups, organise day-to-day logistics of women's groups. facilitate women's group meetings and discussions, guide the implementation of strategies and link to and communicate with individuals and organisations beyond the groups.</li> <li>• who are dedicated and committed to the women's groups and their aims and objectives, able to relate positively with others, knowledgeable about mother and child health issues, hardworking, clear that they are working for the benefit of the whole community and not for personal gain and respectful of the community members they are leading.</li> </ul>
<p>Community members organise themselves to socialise and address their broader concerns by forming organisational structures:</p> <ul style="list-style-type: none"> <li>• including sub-women's group, women's group and area level committees which are linked together in a hierarchical framework from sub-group to district level committees.</li> <li>• new to the communities or by merging with existing structures</li> <li>• which organise communities to address MCH issues, guide the planning, implementation and monitoring and evaluation of strategies to solve MCH problems and facilitate communication between community members and individuals, groups and organisations within and outside communities.</li> <li>• which have a sense of cohesion and unity amongst the members, are democratically managed to accommodate the views of all members, are committed to represent the views of all community members rather than their own self-interest, are strong, independent and self-reliant and have a clear understanding of their specific and distinct roles and responsibilities.</li> </ul>
<p>Community members mobilise resources and use them prudently in women's groups:</p> <ul style="list-style-type: none"> <li>• directly and indirectly by mobilising other resources first that would allow them to mobilise the desired resources.</li> <li>• exclusively from within the community, exclusively from financial, non-governmental and governmental organisations outside the community or from within and outside the community.</li> <li>• in the form of new resources or by accessing existing resources.</li> <li>• in the for of physical, human and financial resources.</li> <li>• democratically and inclusively, .</li> <li>• in a process led by committees, by women and also including the assistance of men</li> </ul> <p>Community members use resources prudently by distributing resources in women's groups:</p> <ul style="list-style-type: none"> <li>• democratically and inclusively, fairly, equally, without discrimination, uncorruptly and freely or for a small fee.</li> <li>• to all groups within communities and community members in nearby communities.</li> </ul>
<p>Community members formed partnerships, coalitions and alliances with others based on shared goals by forming links between women's groups and others:</p> <ul style="list-style-type: none"> <li>• including with individuals and groups within the same community, with other women's groups in other communities and with external organisations.</li> <li>• to access resources, to share responsibility for addressing MCH problems, to mobilise support and participation from other community members and to coordinate action to address MCH problems.</li> <li>• which were led by women's groups, had shared leadership between women's groups and the partner.</li> <li>• which involved equal power-sharing between partners, were based on clarity between partners over tasks, resources and responsibilities and which involved clear communication between partners.</li> </ul>
<p>Community members developed critical consciousness of the root causes of MCH problems and actions to address these by asking why MCH problems arise:</p> <ul style="list-style-type: none"> <li>• and identifying the socio-environmental risk factors affecting them and feeding these into a process of critical reflection.</li> <li>• in a democratic and inclusive manner.</li> </ul>
<p>Community members received power to take control of the women's group programme by forming equitable relationships with the external agent:</p> <ul style="list-style-type: none"> <li>• which built capacities in women's group members to participate, assess problems, lead, mobilise resources and link with others.</li> <li>• which gradually handed over responsibility to facilitate and implement the women's groups through a clear exit strategy.</li> <li>• which involved sharing of power and cooperation, equality in status of knowledge of community members and external agent and a clear understanding of roles and responsibilities.</li> </ul>
<p>Community members took control of decision-making of the women's group programme by taking control of programme management:</p> <ul style="list-style-type: none"> <li>• including planning, implementation and evaluation of women's groups, group meetings and strategies to solve MCH problems.</li> <li>• in a way that ensured representative inputs from all stakeholders, democratic and participatory involvement of all community members.</li> <li>• that ensured free, inclusive, united, transparent and accountable decision-making.</li> </ul>

*Table 5b: Summary of how women's group members in some communities failed to organise and mobilise themselves to take action to improve MCH*

<p>Community members fail to come together with others in similar circumstances by participating in women's groups:</p> <ul style="list-style-type: none"> <li>• in low and homogeneous numbers.</li> </ul>
<p>Community members fail to identify common concerns and solutions by assessing problems in women's groups and:</p> <ul style="list-style-type: none"> <li>• failing to identify a wide range of MCH problems.</li> <li>• excluding the views and opinions of a number of different groups.</li> </ul>
<p>Community members fail to receive direction and structure from local leaders developed in women's groups:</p> <ul style="list-style-type: none"> <li>• who abused their position to gain disproportionate access to resources.</li> <li>• who acted inappropriately to gain other resources.</li> <li>• who lacked dedication, commitment and interest in women's groups and their aims and objectives.</li> </ul>
<p>Community members fail to organise themselves to socialise and address their broader concerns by forming organisational structures:</p> <ul style="list-style-type: none"> <li>• which failed to organise community members to address MCH issues, failed to guide implementation of strategies, and failed to facilitate communication between community members within communities.</li> <li>• which worked for their own personal interests rather than representing the views of all community members, which lacked of cohesion and unity so to cooperate effectively over common objectives, which were often in conflict, which had an inactive nature and which lacked a clear understanding of their distinct roles and responsibilities.</li> </ul>
<p>Community members fail to mobilise resources by failing to mobilise resources in women's groups:</p> <ul style="list-style-type: none"> <li>• from within the community, exclusively from financial, non-governmental and governmental organisations outside the community or from within and outside the community.</li> <li>• in the form of new resources or by accessing existing resources.</li> <li>• with the consultation and involvement of community members.</li> </ul>
<p>Community members failed to form partnerships, coalitions and alliances with others based on shared goals by forming links between women's groups and others:</p> <ul style="list-style-type: none"> <li>• which were top-down and led by the partner.</li> <li>• which involved power differentials between partners and lack of respect from partner for community members.</li> </ul>
<p>Community members failed to develop critical consciousness of the root causes of MCH problems and actions to address these by asking why MCH problems arise:</p> <ul style="list-style-type: none"> <li>• and failed to identify the socio-environmental risk factors affecting them.</li> </ul>
<p>Community members failed to receive power to take control of the women's group programme by forming equitable relationships with the external agent:</p> <ul style="list-style-type: none"> <li>• which did not build the capacities of community members to mobilise resource resources.</li> <li>• which did not gradually hand over responsibility to facilitate and implement the women's groups through an unclear exit strategy.</li> <li>• which involved a lack of power sharing with more power resting with the external agent.</li> </ul>
<p>Community members failed to take control of decision-making of the women's group programme by not taking control of programme management:</p> <ul style="list-style-type: none"> <li>• including implementation of women's strategies to solve MCH problems.</li> </ul>



## **Chapter 6: Results - The capacities of women's group members to organise and mobilise themselves**

### **6.1 Chapter overview**

The data shows that the organisation and mobilisation of women's group members described in chapter 5, was determined by the abilities built and opportunities offered through the intervention to participate (6.2), assess problems (6.3), lead (6.4), form organisational structures (6.5), mobilise resources (6.6), link with others (6.7), ask why (6.8), form equitable relationships with the external agent (6.9) and manage the programme (6.10).

### **6.2 Capacities of community members to participate in women's groups**

#### **6.2.1 Knowledge of community members about participation in women's groups**

In most communities, through the intervention the community members strengthened their knowledge about participating in women's groups, their awareness of participation for the health and wellbeing of women and its wider social and economic benefits.

*"There is need for my participation in saving the lives of mothers and children. I was being called to go and assist to the vegetable gardens but I was refusing, not knowing that the beneficiaries will be our own families in getting the iron and nutrients" (FGD - 2905 - 18.10.10)*

Through the intervention they also realised that participation could allow them to learn things from each other.

*"In order to have a strong group, we need to pull up our efforts by encouraging each other to attend meetings because we can share different knowledge" (FGD - 4104 - 23.08.10)*

Finally, through the intervention they raised their awareness that in groups they had their potential to more powerfully and effectively address the MCH problems, than if they worked as individuals.

*"A problem shared is halved. You cant learn by staying at home. It is important to meet and discuss issues and problem with friends. United we stand" (OBS - 3 - 56 - 10.05.05)*

In contrast, in a few other communities, the intervention failed to raise the awareness of community members about the potential benefits of participating in women's groups.

*"There was a lot of back biting. What used to happen is like soon after a meeting, people would later start analysing the meeting where all that was discussed at the meeting was rubbished. That there would never be anything tangible from MaiMwana that the community would benefit, as such, there is no need for us to commit ourselves to this group. Such discussions demoralised people to the extent that every body minded their own affairs" (FGD - 4104 - 23.08.10)*

It also failed to clarify how serious MCH issues were and that they warranted greater attention compared to many of the other problems facing communities.

*"Attendance has decreased because in groups they only discuss maternal and neonatal issues. These are not the only important things going on in communities" (OBS - 9 - 186 - 26.04.06)*

Finally, it failed to clarify what the women's group intervention aimed to achieve or how it would work in practice.

*"Let me comment on the issue of taking part in the mother and child activities, though I am not part of the women's group. I had no any other knowledge on how these women participate in their activities...now, regarding to your visit today, it's when I will get from you how better the participation is through the women's groups" (FGD - 2905 - 18.10.10)*

This lack of clarity was compounded by misunderstandings amongst community members that the intervention failed to address. In particular it failed to clarify what was discussed in women's groups. This meant that in some cases they community members concerned that the issues discussed might be culturally inappropriate or that the women's groups sought to empower women at the expense of men.

*"That was what we were hearing [that women's groups involve obscene language] from the other quarters of the community but not from the group members, so we were saying that this is against our cultural norms of human respect. That is why we decided not to join the group...as I have said earlier on that all what we were hearing was that whenever these women were meeting, they were talking obscene*

*which was against our cultural values, so I was not interested in any participating to their activities. What we were hearing was like they were empowering the women on the expense of men, so that men should no longer take control of the household's activities...there were some men that were taking part in these activities but I was taking them as the ones that were also advocating and empowering women to be on the forefront of doing obscene things to the community. I was really against this attitude doing things which were obscene" (FGD - 2905 - 18.10.10)*

### **6.2.2 Opportunities for community members to participate in women's groups**

In most communities, through the intervention the community members received adequate opportunities and support to participate in women's groups.

*"[The women's group is] an opportunity. Do you think we could have gathered today if it were not for your coming?...Those who were lazy and those who were becoming lazy have today known that we still have your blessings and they may now think of coming back and participate in our activities and realise that what ever we do is important" (FGD - 4104 - 23.08.10)*

In contrast, in a few other communities, although the intervention established women's groups, it failed to persuade members not to restrict the membership of the groups through rules and regulations. These membership rules and regulations specifically restricted the participation of certain community groups including: women who had never given birth; men; and any community members once the group had reached a certain stage in the cycle or a certain size.

*"There is no isolation of any case in our community when doing these MCH activities. All women of different ages provided they have given birth are involved. The only segments of people that are not involved are the girls [women who had never given birth]" (FGD - 2905 - 18.10.10)*

### **6.2.3 Attitudes of community members towards participation in women's groups**

As discussed above, in most communities, community members strengthened their knowledge, skills and opportunities to participate through the intervention. This subsequently changed their attitudes such as motivating them to participate in women's groups and other MCH activities.

"Really in our villages women and babies are dying and hopefully with the coming of MaiMwana they will decrease. Now that communities have known the objectives of MaiMwana many will come [to the women's groups] the next time and will discuss issues with other women who did not come" (OBS - 3 - 11 - 08.04.05)

### **6.3 The capacities of women's group members to assess problems**

#### **6.3.1 Knowledge of women's group members about problem assessment**

In most communities, through the intervention, the women's group members developed their knowledge about MCH problems, the factors that contribute to these problems, solutions to prevent and manage them and strategies to implement solutions in practice.

*"The facilitator who stays at Nkhwazi was the one who was teaching all these things on safe motherhood. After teaching us, then with the guidance of the chairlady, we were calling for a group discussion to share the health practices issues that she presented to us. We were able to know why we are having different health problems both to mothers and children, and were able to contend them by having some solutions" (FGD - 1006 - 30.10.10)*

The knowledge developed through the intervention was additional to the knowledge that members already had about these issues. Knowledge that existed because, between them, they had either experienced many of these issues themselves or knew someone who had experienced them.

*"We were able to identify the problems because the problems are ours; they befell us so it was not difficult for us through the group to identify the problems" (FGD - 2304 - 14.09.10)*

In these communities, the members also became aware of how serious MCH problems were and the importance of addressing them.

*"We are motivated [to assess problems] by looking at the magnitude of the MCH problems that we had previously, which were on the higher side as compared to what we have now because we are following these modern methods. This is what has strengthened and motivated us" (FGD - 2304 - 14.09.10)*

Through the intervention they also raised their awareness of the need to first assess their health problems so they could identify possible solutions and take appropriate action.

*“The other change of action is that whenever someone has fallen sick of malaria, we are rushing to the hospital for a medical attention unlike in the past when we would just buy any medicine from the local groceries without any prescription; this tendency was causing other health problems. All these changes are coming because of the influence this MaiMwana women’s group, it has done a lot to help us know how important it is to assess the health problems and getting their solutions” (FGD - 3802 - 09.09.10)*

In contrast, in a few other communities, the intervention failed to strengthen the knowledge of women’s group members about the MCH problems facing them.

*"In needs assessment, some groups, finding it difficult to probe for more detail on problems - what are they? Their essential newborn care knowledge...is not developed enough" (OBS - 4 - 29 - 06.06.05)*

Furthermore, they did not understand the definition of the neonatal period, which meant they often confused the neonatal and infant and child periods, or of what constituted a MCH problem, which meant they excluded problems they considered to be too general. Finally, they did not have a clear understanding of what criteria to use to define a problem as a priority, which meant they often failed to prioritise the most important MCH problems facing them.

### **6.3.2 Skills of women’s group members to assess problems**

In most communities, through the intervention, the women’s group members strengthened their skills to assess their MCH problems and potential solutions to these problems.

*“We also learnt some other things that we did not know before MaiMwana came like needs assessment and prioritising. We did not know about this in this village till the coming of MaiMwana and formation of the women’s group” (FGD - 1701 - 25.08.10)*

One particular skill that was built was in public speaking, which allowed members to more effectively and confidently share their personal experiences and views during problem assessment discussions.

*“Women believe each other and they have the capacity of public speaking. Women are able to express themselves to the public, though*

*we have the problem of male participation to MCH issues, we have strong evidence that some men delegate their wives to present them on some important issues in MCH” (FGD - 3802 - 09.09.10)*

### **6.3.3 Opportunities for women’s group members to assess problems**

In most communities, through the intervention, the women’s group members were provided with opportunities and support to come together to share and collectivise their experiences and knowledge of MCH problems and solutions.

*“To my point of view, I think the coming of this women’s group is a great opportunity, because women are able to discuss many issues affecting them and their families. Just imagine they are able to discuss...the means how to prevent malaria. This is encouraging” (FGD - 3802 - 09.09.10)*

They also received opportunities to gather the views of a wide range of community members outside the groups. In this way, non-group members were also provided with had opportunity to share their knowledge and experiences.

*“Through the establishment of the group we found out that men...could help us assess the problems and find solutions to those problems. So, we found this idea of going out [from the group] to discuss issues both men and women very helpful” (FGD - 2304 - 14.09.10)*

In contrast, in a few other communities, the intervention failed to provide adequate opportunities for women’s group members to assess their problems. Usually in these communities problem assessment was carried out in a top down manner led by the ZFs or other knowledgeable individuals precluding the opportunity for members to assess problems themselves.

*"Some groups discuss problems they have been told affect them rather than the ones that actually do...this is also the case in prioritisation" (OBS - 24 - 151 - 08.06.09)*

Furthermore, in these communities the intervention failed to prevent the exclusion of some community groups from the problem assessment process. In particular, men and non-group members of both genders were underrepresented in the problem assessment process in these communities as group members decided not to consult them.

*“We felt that most of the problems affected us women and men were [only] involved at the end [of the women’s group cycle] when the main problems had already been assessed” (FGD - 2304 - 14.09.10)*

#### **6.3.4 Attitudes of women’s group members towards problem assessment**

As discussed above, in most communities, women’s group members strengthened their knowledge, skills and opportunities to assess their problems through the women’s group intervention. This subsequently changed their attitudes, such as motivating them to engage in a process of problem and solution assessment.

*“When a village is reported to have two or three people sick at the same time we become anxious and interested to know what is happening. As a result, we quickly meet to brainstorm and share ideas on how best to keep the outbreak controlled that it does not spread to other people” (FGD - 2304 - 14.09.10)*

### **6.4 The capacities of women’s group members to be local leaders**

#### **6.4.1 Knowledge of women’s group members about local leadership**

In most communities, through the intervention, the women’s group members strengthened their about local leadership. In these communities the members became aware of how to lead women’s groups and understood the roles and responsibilities of leaders, how to elect them and the characteristics that define them.

*“I want to agree with the others that a leader should be active and humble. A leader should also be knowledgeable and dedicated to advance the objectives of the group that they are leading” (FGD - 1701 - 25.08.10)*

They also became aware that the presence of local leaders would help to better organise the women’s groups and make them more effective.

*“The knowledge to elect leaders also came in because we wanted our group to develop and run effectively. That is why we thought of having leaders because without leaders the group could not advance” (FGD - 1701 - 25.08.10)*

In contrast, in a few other communities, the intervention failed to strengthen the knowledge of women’s group members about how to lead women’s groups.

*“We were lacking the direction from our leaders...had it been that the [ZF] was active with us, we would have gained a lot of leadership knowledge and skills which eventually would change our attitudes. But with the status of our non-existence, non-active group, it’s hard to mention the attitude changes” (FGD - 1006 - 30.10.10)*

#### **6.4.2 Skills of women’s group members about local leadership**

In most communities, through the intervention, the women’s group members strengthened their general and specific leadership skills including: group working skills, activity implementation skills, conflict resolution skills, and minute taking and report writing skills. Furthermore, it strengthened the skills they needed to effectively organise and manage the groups.

*“She [the chairlady of the women’s group] had the leadership capacity and was able to organise meetings and she was asking all the group members to be punctual all the time so that whatever has been set on the agenda should be accomplished in time” (FGD - 1006 - 30.10.10)*

In contrast, in a few other communities, the intervention failed to strengthen skills of women’s group members in local leadership. In these communities the members did not receive group development skills, activity implementation skills and committee formation and management skills.

*“My comment is that there is a need to have improved capacities of our leaders through training in team or group development, knowledge in the better steps to follow in activity implementation and good organisation structure development” (FGD - 1006 - 30.10.10)*

#### **6.4.3 Opportunities for women’s group members to lead**

In most communities, through the intervention, the women’s group members were provided adequate opportunities and support to become leaders in the groups. In part this was achieved by supporting members to democratically elect their own local leaders from amongst themselves.

*“We are privileged to elect leaders of our choice without being forced” (FGD - 1701 - 25.08.10)*

#### **6.4.4 Attitudes of women’s group members towards local leadership**

As discussed above, in a few communities the intervention failed to strengthen the knowledge, skills and opportunities of women’s group members to take the lead. This subsequently failed



to change their attitudes such as failing to motivate them to become local leaders for the groups.

*“In particular people think that, or rather we think that those of us who are leaders should receive a little cash. That is what the people think of as a form of motivation” (FGD - 4104 - 23.08.10)*

## **6.5 The capacities of women’s group members to build organisational structures**

### **6.5.1 Knowledge of women’s group members about forming organisational structures**

In many communities, through the intervention, the women’s group members strengthened their knowledge about the formation of organisational structures. Members became aware of how to form committees, how to elect committee office bearers and the characteristics these leaders should have to ensure the structures operated effectively.

*“The knowledge that we have gained is that our committee should be dedicated and strong. We want our committee to forge ahead so that we should still fight to end maternal and child mortality” (FGD - 0206 - 30.07.10)*

### **6.5.2 Skills of women’s group members in forming organisational structures**

In many communities, through the intervention, the women’s group members strengthened their skills to form organisational structures including” skills in committee formation, group dynamics and how to conduct committee meetings and discussions. Furthermore, as discussed above, local women’s group leaders in many communities, developed the skills necessary to lead the organisational structures, such as conflict resolution skills.

*“We had a women’s group vegetable garden down there. There was a faction within the group that decided to boycott involvement in the dimba cultivation for their own reasons. Our [committee] talked to this faction which had dissenting views to the point that they started participating in the dimba cultivation” (FGD - 1701 - 25.08.10)*

In contrast, in a few other communities, the intervention failed to strengthen the skills of women’s group members and group leaders to form organisational structures. In particular it failed to develop their organisational skills.

*“I think the main issue should be improving training to those that will be elected into the new committee. They should have group leadership skills. My observation is that there is lack of skills in the leaders” (FGD - 2508 - 06.09.10)*

### **6.5.3 Opportunities for women’s group members to form organisational structures**

In most communities, through the intervention, the women’s group members received opportunities and support to form organisational structures.

*“The other thing which I think is really important is calling of a community meeting [meeting one]. This meeting involved all the subjects of Jefitala village regardless of being member of the group or not. All people were told of the group objectives, they were asked to actively participate and contribute whatever they think may improve the activities in achieving MCH. Through this same meeting the community empowered the committee to take the lead in MCH activities. If no community meeting had been called, then we would achieve nothing as they will still be disjointed, there would be no unity” (FGD - 2508 - 06.09.10)*

## **6.6 The capacities of women’s group members to mobilise resources**

### **6.6.1 Knowledge of women’s group members about resource mobilisation**

In many communities, through the intervention, the women’s group members strengthened their knowledge about the resources that were required to implement the strategies they developed to solve their MCH problems.

*“After critically assessing the problems that pregnant mothers have, we noticed that most of the times when they have a hypertension, mostly it occurs because of insufficient blood supply. Through trainings, we learnt that honey is a good supplement of iron thereby increasing the volume of blood. We reported this prioritised need to our facilitator who liaised with MaiMwana and other agents; they provided us with two beehives. Later on we liaised with another organisation that gave us other five beehives, making the total number to seven. We have managed to reduce the problem of hypertension in our Nyamawende area with this bee keeping” (FGD - 1506 - 22.10.10)*

They also became more aware of the potential that the resources they mobilised had to improve their lives and help them solve these problems.

*“It was all gender participating to these mobilisation processes, we were all aware of the benefits that we will enjoy if we could manage to mobilise different resources that we were prioritising...we have a lot of confidence as we know that whatever we want to mobilise will be of our own benefit” (FGD - 1506 - 22.10.10)*

Finally, through the intervention, they raised their awareness of which individuals, groups and organisations, within and outside communities, might be able to provide the resources they needed to address these problems.

#### **6.6.2 Skills of women’s group members in resource mobilisation**

In many communities, through the intervention, the women’s group members strengthened their skills to organise themselves to mobilise resources.

*“We have the knowledge of organizing ourselves for discussions, brain storming and encouraging each other that we can manage [to mobilise] all that we need” (FGD - 1506 - 22.10.10)*

For example, they strengthened their skills in proposal writing.

*“We have learnt how we can lobby to other partners, through our reports writing, we have learnt how we can develop a simple request or proposal for assistance” (FGD - 1506 - 22.10.10)*

Another example is that they strengthened their skills in liaising with individuals, groups and organisations and lobbying for necessary resources.

*“Yes, just to cut you short, we have the skills in linking and lobbying with other organisations. We got this skill through our facilitator who was telling us how we can manage to talk and lobby with organisations for assistance. The facilitator was the key factor in producing these linking skills...we have set up a lot of committees and task forces to facilitate different mobilisations, they are skilled in liaising and lobbying, that’s why we are achieving a lot” (FGD - 1506 - 22.10.10)*

In contrast, in a few other communities, the intervention failed to strengthen the skills of women's group members to mobilise resources. In particular it failed to develop their skills to organise themselves and thus to mobilise and lobby for resources from individuals, groups and organisations.

"Group struggling to mobilise necessary resources because not very well planned. They lack skills and organisation and links with others" (OBS - 18 - 156 - 12.11.07)

### **6.6.3 Attitudes of women's group members towards resource mobilisation**

As discussed above, in many communities, women's group members strengthened their knowledge, skills and opportunities to mobilise resources through the intervention. This subsequently changed their attitudes, such as building their confidence and motivation to mobilise resources themselves.

*"We have the ability to mobilise the resources for anything that we need within our group" (FGD - 2905 - 18.08.10)*

Furthermore, it developed their willingness to contribute and share their own personal resources for use by the whole community.

*"We were only 8 group members as such we could not manage to contribute all the money which is why we involved the whole village. Those who managed contributed those who could not, did not" (FGD - 3302 - 24.09.10)*

In contrast, in a few other communities, the intervention failed to strengthen the knowledge and skills of women's group members to mobilise resources. This subsequently failed to change their attitudes, such as failing to encourage them to share their personal resources for use by the whole community.

*"The main thing that made this activity to be a failure was what the group members were advised to contribute money towards the purchase of vegetable seeds and fertilizer. People were not willing to do so, as they thought that it was the responsibility of the external agent to buy and bring them to the group" (FGD - 1006 - 30.10.10)*

## **6.7 The capacities of women's group members to link with other people and organisations**

### **6.7.1 Knowledge of women's group members about linking with other people and organisations**

In many communities, through the intervention, the women's group members strengthened their knowledge about linking with others. They became aware of the severity of the MCH problems facing them and that linking with others had the potential to help them to address these problems.

*"We were motivated by the numerous MCH problems; there was a high rate of maternal and child deaths. This motivated us to establish the partnerships" (FGD - 1102 - 21.10.10)*

In these communities, members also became aware that links with others could help them to mobilise the resources they needed to implement solutions to address their problems.

*"We have the problem of malaria in pregnant mothers so we discussed on our group that if we can form a partnership with the health workers they will be providing us with mosquito nets thereby we will protect ourselves from malaria attacks" (FGD - 2505 - 13.10.10)*

For example, they became aware that the links had the potential to bring them resources, such as knowledge about MCH problems and their solutions.

*"When we sat down as a group, we saw that much as the group had started, something was lacking. This was the skill to develop our knowledge. We therefore saw the need to partner with the orphan care group and Partners in Hope. We invited them that they may help us where we were failing so too [linking] with the health department" (FGD - 1102 - 21.10.10)*

Finally, through the intervention they also became aware that linking with other people and organisations had the potential to enable them to more powerfully address their MCH problems than if they worked without partners.

*"We had problems working alone as a group. So when our friends came forward to say let us work together we agreed and they eventually helped us to do what we are doing today like the dimba,*

*maize cultivation and the bicycle ambulance...it has changed considering the fact that a person alone cannot achieve anything meaningful unless you work together. This is why we thought of linking with others like the chief, Partners in Hope so that together we can achieve something” (FGD - 1102 - 21.10.10)*

#### **6.7.2 Skills of women’s group members to link with other people and organisations**

In many communities, through the intervention, the women’s group members strengthened their skills in linking with other people and organisations. In some cases these were general networking skills.

*“We are also capacitated in linking with other groups who can assist us in other problems that we are having in our group and our village” (FGD - 3603 - 07.10.10)*

In other cases these were specific skills, such as proposal writing and lobbying and advocacy skills.

*“The other skill that this women’s group has developed in us is the lobbying skills. We are able to lobby and negotiate with other partners that can assist us in the development of our MCH activities. We linked our group with Total Land Care and we have lobbied for other things. Thanks to MaiMwana” (FGD - 3603 - 07.10.10)*

#### **6.7.3 Opportunities for women’s group members to link with other people and organisations**

In most communities, through the intervention, women’s group members were provided with adequate opportunities and support to form links with other people and organisations.

*“[Stakeholder meetings] brought stakeholders and ZFs and women’s group members together at nodal level. Discussed problems faced by groups and also strategy lists. Discussed and agreed roles and responsibilities of groups, MaiMwana, and local stakeholders. Then filled in and signed MoUs on the basis of agreed roles and responsibilities” (OBS - 16 - 139 - 18.09.07)*

In contrast, in some other communities the intervention failed to provide adequate opportunities for members to form links with others. In some cases the potential partners were present or accessible but they lacked the motivation or dedication to form links with the

women's group members. This was a particularly common attitude amongst local health facilities and health workers.

"Mobile clinic has been hard to implement. The committee had contacted the health facility many times to start to organise this but they book to go to the health facility but the staff don't honour the meeting and give excuses. This is lack of respect from the partner and the lack of assistance has caused demotivation in the village" (OBS - 23 - 38 - 30.10.08)

#### **6.7.4 Attitudes of women's group members towards linking with other people and organisations**

As discussed above, in many communities the women's group members strengthened their knowledge, skills and opportunities to link with others through the intervention. This subsequently changed their attitudes, such as raising their motivation to form links with others.

*"We established these partnerships knowing that when a person works alone or in isolation, you lack knowledge. We felt that we lacked knowledge, skills from other partners to help us achieve our goals. This is why we thought of partnering with others so that we acquire their counsel" (FGD - 1102 - 21.10.10)*

It also developed their confidence to form links with other individuals, groups and organisations.

*"Our confidence has really changed as we are getting good advices from the facilitator on how we can link up with other organisations for our needs. We have managed to link ourselves with different organisations because we are confident that we will manage to lobby and conceive them" (FGD - 3603 - 07.10.10)*

In contrast, in a few other communities, the intervention failed to strengthen the knowledge, skills and opportunities of women's group members about linking with others. This subsequently failed to change their attitudes, such as failing to develop a sense of unity with women's group members in other communities with whom they could potentially form links.

"At the second meeting the Kupweta women did not attend because they were chased away by the Chipumi people" (OBS - 5 - 1 - 17.06.05)

## **6.8 The capacities of women's group members to ask why**

### **6.8.1 Knowledge of women's group members about asking why**

In many communities the intervention failed to strengthen the knowledge of women's group members to ask why. In particular members were not aware of the root social, political and cultural causes contributing to their MCH problems.

### **6.8.2 Skills of women's group members to ask why**

In some communities, through the intervention, the women's group members strengthened their skills to ask why they experienced certain health problems. Members were skilled in critically analysing the root causes of the MCH problems being faced.

*"What I wanted to add up is that these skills have developed the sense of openness in our group. We are free to participate and interact in many activities. The other skill is that one of identifying why we are having health problems like malaria and getting their solutions" (FGD - 3603 - 07.10.10)*

These skills took time to develop. Indeed they were more commonly observed in the later stages of the women's group intervention cycle.

*"In phase IV, during evaluation, they identified new strategies as they started to identify deeper causes and realised that strategies were not working as they were 'superficial'" (OBS - 24 - 144 - 08.06.09)*

### **6.8.3 Opportunities for women's group members to ask why**

Often, through the intervention, women's group members were provided with adequate opportunities and support to ask why. In most communities women's group members were also given adequate time to engage in critical assessment of the root causes of their health problems and were not rushed to identify these causes.

*"For this adult literacy school to be established it took us a long period as we involved ourselves in the process of discussion on our group, identifying the problems and strategizing on them. If I can recall well, this organisation of MaiMwana came into our community in 2003, so for the group to be established, organise ourselves, starting strategizing up to the extent of realizing that illiteracy is contributing to our health, it was a long period" (FGD - 3603 - 07.10.10)*



## **6.9 The capacities of women's group members to form equitable relationships with the external agent**

### **6.9.1 Knowledge of women's group members about forming relationships with the external agent**

In most communities, through the intervention, the women's group members strengthened their knowledge about forming relationships with the external agent. In particular they became aware of the principles, aims and objectives of the intervention and thus the form and function of the relationships they could form with the external agent.

*"But I think all these problems depends on personal understanding and integrity, those that were there at the beginning of the women's groups knows and understands how the group works, their program implementations is different to the other organisations" (FGD - 0205 - 03.11.10)*

Through the intervention the members also became aware of their roles and responsibilities within the relationships and the roles and responsibilities of the ZFs, FTOs and SFTO. Finally, they also became aware that relationships with the external agent had the potential to bring improvements to the health and wellbeing of women and children.

*"I should comment that these people are not really committed. Once they see the facilitator is coming either for a meeting or any other group activities, they run away. You can see those people taking hoes to the garden others just lock themselves up into the houses. Now, if they are running away from the facilitator, how can they expect good thing to come into this group. Whenever we see the facilitator coming, we believe that good things are coming our way; we may see developments in our community. We know that she is doing all these in order to bring health lives to our babies and mothers and the entire community. They are involved in the dimba cultivation, it's only these women that benefit from the vegetables. The entire household is benefiting, this is a source of nutritious food readily available in our community, so why running away from the facilitator. This is a shame" (FGD - 2508 - 06.09.10)*

In contrast, in a some other communities the intervention failed to strengthen the knowledge of women's group members about relationships with the external agent. In particular they were not made aware of the principles, aims and objectives of the intervention and thus the form and function of the relationships they could form with the external agent.

*“Facilitator: Did the project say at that meeting that you would receive hand outs? What exactly did the project say? Because, I am afraid that this misunderstanding might come up because the project is not fulfilling what they had initially promised. What was the agreement at first?”*

*Respondent: It was said that the project had nothing to give out to the people but to do research on expectant mothers and children to find out why there are frequent maternal as well as child mortality, to find out why children die before completing a month. That is the purpose of the project, not to give handouts but to do research on MCH and reduce mortality of children and mothers.*

*Facilitator: Why then did people not understand this? Why did they not have interest on MCH problems as if they do not exist?*

*Respondent: A number of organisations start by telling people that they do not give out hand outs but finally end up giving out some items and people thought it would be one of such things” (FGD - 3302 - 24.09.10)*

#### **6.9.2 Opportunities for women’s group members to form relationships with the external agent**

In most communities, through the intervention, the women’s group members were provided with adequate opportunities and support to form relationships with the external agent. More specifically they had the opportunities to form long-term and stable relationships, in part because the external agent was represented in communities by the ZFs and FTOs who come from and lived locally.

*“One of the opportunities is that we have a facilitator close by and again we are dedicated within our group. When we have encountered a problem, we don’t hesitate to call upon the facilitator to help us and go ahead with our programmes” (FGD - 0206 - 30.07.10)*

This was also facilitated by the fact that the ZFs, in particular, visited the communities regularly and over a long-period of time.

*“The opportunity that exists for us is the presence and availability of a dedicated and committed zone facilitator who visits us regularly to assist us where we lack some knowledge and skills” (FGD - 0206 - 30.07.10)*

In contrast, in a few other communities the intervention failed to provide adequate opportunities for the members to form relationships with the external agent. In these cases, for a range of different reasons, the ZFs and FTOs they did not visit the communities frequently enough.

*“It’s also difficult to mention what exactly we are missing since the facilitator stopped coming to us, we learnt little from her. What I can ask is the resumed and continued coming of the facilitator to our Kamphevu group, so that we can learn many things and then we can enjoy the opportunities” (FGD - 1006 - 30.10.10)*

In some cases the members felt that this reflected an expression of favouritism amongst the external agents for certain communities over their own.

*“There was nothing that the facilitator was doing. Our community is surrounded by many villages like Mlamba, Katsenga but the facilitator was only paying much attention to those village groups, not ours, then this gradually turned down the interest of people in participating to the group activities” (FGD - 1006 - 30.10.10)*

### **6.9.3 Attitudes of women’s group members towards forming relationships with the external agent**

As discussed above, in many communities through the intervention the women’s group members strengthened their knowledge and opportunities to form relationships with the external agent. This subsequently changed their attitudes, such as helping to develop a positive image of the external agent amongst the community members.

*“I don’t think there is any problem with the mode of communication that exists between us and the project because much as we are concerned our facilitator communicates with us regularly and if there is anything, she shares with us as soon as possible. Whenever we need her, she is available. We have no problems with communication process. In summary, MaiMwana is a very good project to us” (FGD - 2902 - 05.11.10)*

Furthermore, it developed a sense of trust and respect for the external agent amongst the members.

*“There is trust because in the past when the project was just being introduced to us, it was despicable. But looking back at what the*

*project has done, the village has since built its trust on the project. Through all the programs that we have e.g. by arranging regular meetings where the project's facilitator teaches us and it is through these lessons that we have built our trust on the project as we have learnt what we did not know previously" (FGD - 2902 - 05.11.10)*

In contrast, in some other communities, the intervention failed to strengthen the knowledge and opportunities for women's group members to form relationships with the external agent. This failed to change their attitudes and even helped to develop a negative image of the external agent amongst the members.

*"But most of our community members think negatively of MaiMwana and take their initiatives as useless and baseless" (FGD - 0205 - 03.11.10)*

Furthermore, it developed a lack of trust for the external agent amongst the members.

*"The other problem was that the facilitator, she was not recognizing us whenever there is training at Nkhwazi, she was only taking the participants from the other groups. So, we felt being neglected and cheated. That's why we stopped participating in group meetings" (FGD - 1006 - 30.10.10)*

Finally, it developed a lack of motivation amongst the members to form relationships with the external agent.

*"Many communities around us like Amos Village are crying by saying that the project favours some villages but they rejected the project in the first place saying that MaiMwana was useless" (FGD - 2902 - 05.11.10)*

## **6.10 The capacities of women's group members to manage the programme**

### **6.10.1 Skills of women's group members to manage the programme**

In most communities, through the intervention, the women's group members strengthened their skills to manage the women's group programme. For example, they developed skills in: report and minute writing, decision-making, lobbying, management and coordination of groups, delegation, liaising with stakeholders and partners, planning and financial management. In addition, key skills were developed in facilitation of the women's group cycle.

"Women able to conduct meetings on their own" (OBS - 9 - 134 - 04.04.06)

In contrast, in a few other communities, the intervention failed to strengthen the skills of women's group members to manage the programme and coordinate the groups

*"The main thing that we are lacking on our group is training, whereby we can get the other skills to manage our health activities and how to improve our group coordination" (FGD - 2403 - 29.10.10)*

Furthermore, key skills in facilitating women's group meetings were also not developed.

"In meeting eight many of the ZFs are taking the lead in all aspects of presentation - women not able" (OBS - 8 - 139 - 13.05.12)

#### **6.10.2 Opportunities for women's group members to manage the programme**

In most communities, through the intervention, the women's group members were provided with adequate opportunities and support to manage the women's group programme.

*"Yes, we should be thankful to MaiMwana because we have gained a lot of knowledge in managing our MCH activities. We were let aside to work on our own, we have managed to achieve a lot" (FGD - 2403 - 29.10.10)*

In these communities the key opportunity for members came from the external agent building their capacities and handing over increasing responsibility for them to take control.

*"There is an improved management of our group; we have the group facilitators who always lead in our discussions. Anytime we are meeting, they give out all the skills in order to make the group active. We don't worry even if the Zone Facilitator doesn't come because we know what we are supposed to do" (FGD - 1506 - 22.10.10)*

#### **6.10.3 Attitudes of women's group members towards programme management**

As discussed above, in many communities, through the intervention the women's group members strengthened their skills and opportunities to manage the women's group

programme. This subsequently changed their attitudes including developing their commitment to manage the women's group programme.

*“Now, this group managed to acquire the skills from MaiMwana, they can work and implement them on their own just because they are committed, organised in needs assessment and prioritising. They are united and the structures that were formed are working to the objective targeting of the group” (FGD - 2403 - 29.10.10)*

## **6.11 Summary**

Table 6a (page 253) presents a summary of the capacities built in women's group members in many communities to organise and mobilise themselves to take action to improve MCH.

The findings show that, in most communities, the intervention developed the knowledge and skills of community members, offered them opportunities and thus encouraged them to form small mutual groups. This included the capacities necessary for community members to meet actively with others sharing similar concerns and to democratically and effectively identify the MCH problems facing them and the potential solutions to these problems.

The findings show that, in most communities, by forming small mutual groups, the intervention provided a forum for members to gain further knowledge, skills, opportunities and thus encouragement to better organise and mobilise themselves to form community organisations. This included the capacities necessary for identifying and electing effective and trustworthy local leaders and forming powerful and structured local and area level committees.

The findings show that, in most communities, by forming community organisations, the intervention provided the structure and direction for members to gain further knowledge, skills, opportunities and thus encouragement to better organise and mobilise themselves to form partnerships. This included the capacities necessary for effectively accessing resources and distributing them equally and for identifying, forming and managing relationships with other individuals, groups and organisations sharing similar goals.

Finally, the findings show that, in many communities, by forming partnerships, the intervention provided the breadth of experiences and perceptions necessary to enable community members to look beyond their immediate concerns and identify the root causes underpinning their health disadvantages. This included the capacities and time necessary to explore beneath the surface of the MCH problems affecting them, identify their social and environmental causes and start to take the social and political actions necessary to address them.

Thus, the findings reveal that in many communities the intervention built the capacities that enabled community members to increasingly organise and mobilise themselves to take action to address their MCH issues. The findings also reveal that these capacities and the related responsibilities were gradually developed in the community members by MaiMwana Project staff.

Table 6b (page 254) presents a summary of the capacities that the intervention failed to build in women's group members in some communities to organise and mobilise themselves to take action to improve MCH.

The findings show that, in some communities, the intervention failed to encourage community members to form small mutual groups because it failed to develop their knowledge and skills or offer them all adequate opportunities. This included the understanding necessary to effectively identify the MCH problems facing them and the potential solutions to these problems.

The findings show that, in some communities, the intervention failed to encourage community members to better organise and mobilise their small mutual groups into community organisations. The intervention did not provide an adequate forum for members to gain further knowledge, skills, opportunities themselves. This included the capacities they needed to develop effective leadership and structured local and area level committees.

The findings show that, in some communities, the intervention failed to encourage community members to develop the structure and direction necessary to link with other community organisations, individuals and groups and form partnerships. This transition was not achieved because the intervention failed to develop the necessary knowledge and skills and offer the appropriate opportunities for them to do so. This included failing to develop the capacities and motivations necessary to effectively mobilise resources and share them equally with those in need and the complex skills needed to identify, form and manage relationships with other individuals, groups and organisations sharing similar goals.

Finally, the findings show that, in some communities, the intervention failed to develop the knowledge and skills and provide the breadth of experiences and perceptions necessary for community members to look beyond their immediate concerns and identify the root causes of their poor MCH. As a result, the community members did not develop the motivation to start to take social and political actions necessary to address these root causes.

Thus, the findings reveal that in some communities the intervention failed to build the capacities that would enable community members to increasingly organise and mobilise themselves to take action to address their MCH issues. The findings also reveal that these

capacities and their related responsibilities were not developed in those communities where MaiMwana Project staff worked less effectively.



*Table 6a: Summary of capacities of women's group members in many communities to organise and mobilise themselves to take action to improve MCH built by the women's group intervention*

<p>Awareness of:</p> <ul style="list-style-type: none"> <li>•the potential benefits of participation in women's groups for MCH; how participation in women's groups might allow sharing and learning about MCH issues; and the potential of participation in women's groups to allow the more powerful and effective action on MCH issues.</li> <li>•the health problems affecting mothers and children; contributing factors to problems; solutions to problems; and strategies to implement these solutions in practice</li> <li>•the importance of assessing MCH problems and finding solutions; the seriousness of the MCH problems; and that assessing the MCH problems and solutions could help them improve the health and ultimately reduce the mortality of women and children.</li> <li>•the roles and responsibilities of leaders; how to elect leaders; characteristics that define good leaders; how to lead; and the benefits that leaders might bring for mother and child health.</li> <li>•how to form committees; and how to meet as committees.</li> <li>•what resources needed to be mobilised to prevent and manage MCH problems; the potential mobilised resource could bring for MCH; and where and from whom the resources could potentially be mobilised.</li> <li>•the potential benefits of linking with others for mobilising resources and increasing capacity to address MCH problems.</li> <li>•the principles, aims and objectives of MaiMwana project; clarity over roles and responsibilities of communities and MaiMwana project; and that relationships with MaiMwana had the potential to bring benefits for MCH.</li> </ul>
<p>Skills in:</p> <ul style="list-style-type: none"> <li>•assessing MCH problems; identifying solutions to MCH problems; and prioritisation of MCH problems and solutions.</li> <li>•public speaking.</li> <li>•leadership; activity implementation; conflict resolution; minute taking and report writing.</li> <li>•group working; group formation; group dynamics; conducting meetings and discussions; and leadership.</li> <li>•proposal writing; liaising with potential donors; and lobbying donors for resources.</li> <li>•advocacy.</li> <li>•critical assessment of root causes of MCH problems.</li> <li>•programme management and facilitation of women's groups.</li> </ul>
<p>Opportunities to:</p> <ul style="list-style-type: none"> <li>•participate in women's groups.</li> <li>•assess MCH problems; prioritise the MCH problems felt to be most important; to identify factors that contribute to the MCH problems; identify preventative and management solutions for the MCH problems; and identify strategies to implement these solutions in practice.</li> <li>•elect local leaders.</li> <li>•form committees at sub-women's group and women's group level.</li> <li>•mobilise resources.</li> <li>•form links with other individuals, groups and organisations.</li> <li>•ask why MCH problems arise; and take time ask why MCH problems arise.</li> <li>•engage with the external agent easily, frequently and over a long period.</li> <li>•manage the women's group programme.</li> </ul>
<p>Attitudes including:</p> <ul style="list-style-type: none"> <li>•Motivation to participate in women's groups, to assess problems, contributing factors, solutions and strategies, to mobilise resources and motivation to link with others.</li> <li>•Confidence to mobilise resources and to link with others.</li> <li>•Willingness to contribute and share personal resources with the rest of the community.</li> <li>•Positive image of, trust and respect for the external agent.</li> <li>•Commitment to management of the programme.</li> </ul>

*Table 6b: Summary of capacities of women's group members in some communities to organise and mobilise themselves to take action to improve MCH that the women's group intervention failed to build*

<p>Lack of awareness of:</p> <ul style="list-style-type: none"> <li>• what the women's groups are doing and seeking to achieve.</li> <li>• the MCH benefits that the women's groups could potentially bring.</li> <li>• the importance of MCH issues.</li> <li>• the health problems affecting mothers and children.</li> <li>• how to define a neonatal child.</li> <li>• how to define MCH problems.</li> <li>• how to define an MCH problems as a priority.</li> <li>• how to lead.</li> <li>• the root causes of MCH problems.</li> <li>• the principles, aims and objectives of external agent.</li> <li>• roles and responsibilities of communities and external agents.</li> </ul>
<p>Lack of skills in:</p> <ul style="list-style-type: none"> <li>• leadership.</li> <li>• organisation.</li> <li>• management.</li> <li>• facilitation.</li> </ul>
<p>Lack of opportunities to:</p> <ul style="list-style-type: none"> <li>• for some groups within communities, to participate in women's groups.</li> <li>• for some groups within communities to assess MCH problems.</li> <li>• link with partners as they are not motivated to work with communities.</li> <li>• form relationships as external agents as they did not frequently visit communities.</li> </ul>
<p>Unchanged attitudes including:</p> <ul style="list-style-type: none"> <li>• lack of motivation to become leaders.</li> <li>• lack of willingness to contribute and share personal resources with the community.</li> <li>• lack of unity between community members in different communities.</li> <li>• negative image, lack of trust and motivation to form relationships with the external agent.</li> </ul>

## **Chapter 7: Results - The outcomes of women's group members organising and mobilising themselves**

### **7.1 Chapter overview**

The data shows that new collective resources and relationships that women's group members could draw on to take control of the social determinants of MCH were generated as they organise and mobilise themselves as described in chapter 5. They are generated as they come together with others in similar circumstances (7.2), identify common concerns and solutions to address their concerns (7.3), provide direction and structure (7.4), become organised to socialise and address their broader concerns (7.5), mobilise resources and ensured they were used prudently (7.6), develop partnerships (7.7), develop critical consciousness of the root causes of their concerns and actions to address these (7.8), transfer power to them to take control of the women's group programme (7.9) and take control of decision-making in relation to the women's group programme (7.10).

### **7.2 The outcomes of community members participating in women's groups**

#### **7.2.1 Interpersonal resources**

##### **Knowledge resources**

In most communities coming together with others allowed community members to share their knowledge and experiences and learn from each other about MCH problems, the factors that contribute to these, solutions to address them and strategies to implement these solutions in practice.

*"This has also helped us to know how to live as a group. Much as you know that a person does not learn alone but as a group, you are able to share knowledge. You may agree with me that there is great advantage to come together and discuss issues as a group because knowledge is wide, people contribute on different levels. Now we have realised that some of the things are preventable through group knowledge" (FGD - 0206 - 30.07.10)*

##### **Skill resources**

In most communities coming together with others also allowed community members to share and learn useful MCH skills.

*"On top of that as you know that it is very difficult to help a person. But this is now happening because of meeting at a group which has*

*enabled us to learn different things from amongst ourselves. People learn a lot of things including domestic chores. One may learn how to do something from a friend which s/he was failing to do” (FGD - 2301 - 03.09.10)*

They also learnt skills related to organising their communities and working in groups to take action and address MCH issues.

*“They gained skills in staying together and getting things well organised. They also have another skill of identifying needs to help other people” (FGD - 2301 - 03.09.10)*

Finally, they learnt skills directly related to identifying and solving MCH problems facing them.

*“Let me just add that on the women’s groups, we sat down with our facilitator and talked about safe motherhood, what is involved and how we can end maternal deaths. So, on this women’s group, after analysis we found out that maternal deaths have reduced” (FGD - 0206 - 30.07.10)*

### **Physical resources**

In most communities coming together with others allowed community members to gain access to collective resources for MCH that had been mobilised or pooled by the women’s groups. These resources ranged from food grown in group gardens to bicycle ambulances that had been lobbied.

*“Yes, it is possible to die because when you are at a group such as the women’s group, you can easily access resources that can be used on MCH which you cannot easily access alone like the bicycle ambulance. That is why she alluded that it is easy to die alone because you cannot easily access the resources at the time that you require them. When you are not a member of the group, you even fail to approach the group as you are not a member while those in the group as members can easily assist each other” (FGD - 3302 - 24.09.10)*

These resources often included funds mobilised from within or outside the community and made available through donations and revolving loan schemes established at the women’s group level.

*“After realizing enough money from the vegetables sells, we buy fertilizer in readiness for the rainy season. The rest of the money is put as revolving loan scheme which members can borrow with an interest to ensure that the money generate some profits. As I am saying right now, members are accessing this money as loans” (FGD - 0206 - 30.07.10)*

In contrast, in a few other communities, the process of participation failed to bring community members together effectively, which affected their abilities to mobilise necessary resources.

*“At first we were so many of us and we thought our group would be very strong and united but suddenly the numbers began to drop to the extent that our teacher (facilitator) could only find as few as only four people. Finally the meetings stopped. Therefore, we failed to mobilise the resources because there were very few of us and not meeting” (FGD - 3302 - 24.09.10)*

### **Psychological resources**

In many communities coming together with others changed the attitudes of community members and developed their sense of confidence and self-reliance that they now had the abilities to address MCH problems. Indeed, members felt they now had mastery over these problems rather than being subject to them as they had been in the past.

*“Without the WG they wouldn’t have received the skills and knowledge they can now apply...’we are really doing something and we are the masters of these things” (OBS - 27 - 138 - 06.04.10)*

It also developed a sense of strength that arose from their understanding that by working collectively with others they had more chance of success than working individually.

*“Many groups said that they had been trying to improve MCH before but only when MaiMwana Project brought groups did they manage. The group process encouraged collective action rather than individualism and thus enabled them to more effectively act to address their concerns” (OBS - 17 - 75 - 05.10.07)*

They also became more motivated to take control of their health problems and address them. This included motivating them to take the lead in teaching and supporting other community members to have better MCH.

*“The main change in capacity [that has come through participation in women’s groups] is the motivation the community has in disseminating the good health messages to the rural masses so as the community should change” (FGD - 2905 - 18.10.10)*

Community members also developed a sense of responsibility and ownership for identifying and addressing the MCH problems they faced including taking on the responsibility to seek care rather than deferring the responsibility for these decisions and actions to others.

*“We feel that we are responsible for the MCH activities and not because we are forced...we are responsible for this because we feel that what we are taught [in women’s groups] is helpful for us and we follow that like going to the hospital whenever need be as compared to the past” (FGD - 2301 - 03.09.10)*

It also changed their perceptions towards traditional and cultural MCH practices. In some cases they came to perceive TBA delivery and traditional gender roles to be negative and health facilities, health workers and male involvement in MCH issues to be positive.

*“The other thing that I can say is that it was very difficult for men and women to be on one group discussing issues about maternal. It was difficult for men couldn’t open up to women, it was like a taboo doing that, but with the coming of this women group we able to share anything about maternal issues. We are able to mention all the problems that women face during delivery and they can know why it is important to mobilise resources for MCH” (FGD - 1506 - 22.10.10)*

In other cases they came to perceive open discussions about MCH issues to be positive rather than treating them as ‘secret women’s issues’ as had been the case in the past.

*“Our culture has changed in the sense that even men now are involved in maternal issues. They are not isolated. They know about motherhood as well as getting involved in such matters. Nothing is hidden, we are doing things together...even women are these days accompanied by their husbands to the hospital on maternal issues such that maternal issues are now not a private subject to men” (FGD - 2301 - 03.09.10)*

Finally, in other cases they came to perceive the involvement of women in decision-making about issues that affected them to be important.

*“Yes, because for instance previously as that woman has said that women were not free to express their ideas let alone have an opportunity or forum for expressing such ideas. Just as you are here today for instance, we could have informed and called the chief to be with us. But here we are without the chief meaning that there is now freedom to expression and association” (FGD - 2304 - 14.09.10)*

### **7.2.2 Interpersonal relationships**

#### **Trust**

In many communities coming together with others helped to develop a sense of unity and trust between them.

*“What I want to say is that through the meetings that we conduct on our group and community level has brought oneness and trust amongst the whole community” (FGD - 2905 - 18.10.10)*

#### **Networks**

In most communities coming together with others also allowed different individuals and groups within communities to associate formally in a way that they had not been able to do previously. In particular different groups of women came together and formed new networks of association within communities.

*“Nobody could come to a neighbour’s house to advise her to go to the hospital let alone advise one another on MCH issues. It was considered an insult. But these days we are open enough to advise a friend and be listened” (FGD - 2301 - 03.09.10)*

Women and men in communities, who were interested in MCH issues, also came together and associated.

*“The participation in MCH activities has brought men and women together in achieving the problems they are concerned of” (FGD - 2905 - 18.10.10)*

Finally, in participating in women’s groups members also developed new links with other individuals, groups and particularly external organisations. Indeed, external organisations preferred to develop links with women’s groups rather than individuals as they felt that the collective nature of women groups made them more reliable and motivated.

*"The Ethel Mutharika Foundation has already identified areas for protection and pumps but the communities had not mobilised to provide protection or resources. In women's group areas the groups had mobilised the community to contribute. As a result, partners preferred to work with them as they were more active" (OBS - 22 - 40 - 28.08.08)*

### **Collective action**

In most communities coming together with others enabled community members to start working collaboratively to bring about improvements in MCH and reductions in mortality. This commonly took the form of implementing collective strategies were implemented to solve the MCH problems that were of general concern to the broader community.

*"Actually before this women's group we were working individually [on MCH issues] but right now we are doing them together as a group...whatever we discuss on the group, is taken out to the community and the community responds with the actions which are done." (FGD - 2905 - 18.10.10)*

## **7.3 The outcomes of problem assessment by women's group members**

### **7.3.1 Interpersonal resources**

#### **Knowledge resources**

In most communities identifying common concerns and solutions raised the awareness of women's group members of their MCH problems, the factors contributing to these problems, their potential solutions and strategies to implement them.

*"We were actually ignorant but because of the coming in of the women's group...we have known and realised the truth...it has changed our capacities in knowledge because when we come together as a group to assess the MCH problem and solutions, we share knowledge amongst ourselves. So that what one does not know the group offers an opportunity to learn things from friends. And when this knowledge is learnt, one is able to look forward and focus on their health" (FGD - 2304 - 14.09.10)*



Members also became more aware of any gaps that existed in their knowledge of MCH issues.

"A woman in the group has goitre. The other women started advising her that she needed a balanced diet but it became clear that they did not know exactly what a balanced diet actually was. 'We need someone to come in and teach us what a balanced diet is'" (OBS - 6 - 170 - 05.08.05)

They also became more knowledgeable of the physiological and behavioural risk factors that contributed to their problems.

*"For the problem of tetanus, we realized that it was because of bad and poor delivery places for mothers so we opted for hospital deliveries. The other problem was putting of herbs and pestle dust on the umbilical cord, this was a bad practice, and it was bringing problems to babies...we realized that the causes of asphyxia are amongst others beer drinking and smoking while pregnant, the other one is none attendance of antenatal. We advised the community to attend antenatal as they can get more advices, they should not drink and smoke while pregnant"* (FGD - 3603 - 07.10.10)

Finally, they also learnt about the solutions that could potentially help them to prevent and manage these health problems and strategies to implement these solutions in practice.

"We learn more...we learn new knowledge about how to solve our problems from the discussions we hold...especially the younger members who are getting relevant information from the other people" (OBS - 7 - 25 - 08.09.05)

### **Skill resources**

In most communities identifying common concerns and solutions also allowed women's group members to share and learn skills from each other such as the identification of danger signs and mother and child care and care-seeking skills.

"Because of [assessment of problems through] the women's group programme we are more equipped with safe motherhood skills than before" (OBS - 12 - 95 - 29.06.05)

## **Physical resources**

In many communities identifying common concerns and solutions enabled women's group members to identify the resources they required to address their MCH problems and formed the basis for action to mobilise these necessary resources.

*“Let me talk about piggery, we started by having group discussions on our needs on MCH. We realized that most pregnant mothers lack nutritious supplementary foods and funds to buy other essentials during the time of pregnancy. We thought that pigs will provide food as well income when sold. So, we asked each and every member of this group to contribute K500.00 which we managed to buy a pig. We discussed on how we may build the pig kraal, so we agreed to contribute another K500.00 each for the construction of the kraal” (FGD - 1506 - 22.10.10)*

## **Psychological resources**

In some communities identifying common concerns and solutions changed the attitudes of women's group members so that they developed a greater sense of ownership over the problems, solutions and strategies identified.

*“We also learnt [through needs assessment] the knowledge that in order for us to reduce or combat some health problems, we have to find solutions by ourselves” (FGD - 2304 - 14.09.10)*

Members also became more motivated to implement the strategies they had identified to solve their problems.

*“So, at first it seemed as if the project or the women's group was for a few people but as a village we have now a vision to stick on to [strategies identified through problem assessment] so that we can still prevent some of the MCH problems like the malnutrition. We are very thankful here at Chimteka because of this project” (FGD - 2304 - 14.09.10)*

Members also developed a greater sense of capability in relation to MCH issues associated with an increased sense of confidence and feeling of control over these problems.

*“There is a change in safe motherhood because of this good process that the group engaged in assessing MCH problems in our community. The families are practicing good child spacing because of the courage*

*that the got from the group assessing these maternal problems. Most of us are now taking almost four years without having another child” (FGD - 3802 - 09.09.10)*

They also developed a greater sense of collective focus on and collective responsibility to address their common MCH issues. Indeed they believed that to address their problems they needed to work together with others rather than as individuals.

*“There have been improved interactions since this assessment of MCH problems and solutions started. For example when a woman had a problem like blood loss; in the past people had nothing to do on such a situation leaving the responsibility to the husband to take care of his wife to the TBA. It was like a family affair. But today, because of coming together as a group assessing MCH problems, when such issues happen it is the responsibility of the neighbours or nearby community members to take the woman to the hospital where she should be helped as soon as possible” (FGD - 2304 - 14.09.10)*

Finally, they changed their perceptions towards traditional and cultural practices. In some cases they came to perceive some traditional practices, such use of traditional medicines and delivery with TBAs, to be harmful.

*“In our old days we were believing that once a woman has delivered we need to stay apart without sleeping together for a period of 6 months, but we have realized with the influence of the women group that these were just cultural believes, we are now only staying 28 days apart with our partners, then we can start sleeping together...We were told in the past that we should be applying pestle dust on the umbilical cord as I have already mentioned, but we have changed this as we have realized this brings health problems to the baby...The other thing was that the baby was being wrapped with herbs around the neck, some herbs were being pasted on the anterior fontanel. This is no longer happening...we realized that these are the things of the past, they were just beliefs nothing to do with us these days...the other thing that I want to add is that in the past the babies were being given herbs to drink, nowadays what we all know is to exclusively breastfed for six months. Then after six months we can start giving some extra foods” (FGD - 3603 - 07.10.10)*

In other cases they came to perceive male involvement in MCH issues, interacting with health services and health workers and talking openly in communities about reproductive health and MCH issues to be important.

*“The other thing is that there is no finger pointing in the families nowadays as all are becoming responsible in family planning. The couple is at liberty to speak issues about family planning and other MCH issues unlike in the past, when they could fear each other” (FGD - 3802 - 09.09.10)*

### **7.3.2 Interpersonal relationships**

#### **Trust**

In many communities identifying common concerns and solutions involved women’s group members sharing personal and at times difficult and sensitive MCH experiences which developed high levels of trust between them.

*“There is trust in our society, just imagine if the couple is free to discuss on family planning, they are able to decide on family planning, trust is there indeed” (FGD - 3802 - 09.09.10)*

#### **Networks**

In many communities identifying common concerns and solutions also encouraged women’s group members to form new links with others with whom they found they shared these issues. In particular new links were established within communities, particularly between men and women, between women’s group members in different communities and between members and external stakeholders.

*“Networks have improved because in the past when a problem arose, it was solved at a household level, just the two of you. But because we are coming together with other villages to assess MCH problems and solutions, we are building good relationships through this assessment. Apart from that our women’s group also works together with an orphan group by helping each other in so many ways” (FGD - 2304 - 14.09.10)*

#### **Social support**

In most communities identifying common problems and solutions equipped women’s group members to provide support to each other and non-members in need.

*“Besides MCH problem assessment and solution there was...mother-to-mother counseling where women were visiting and counseling women in their homes. One Mr. Sitoko said that we made detailed program of who to visit within the month as per certain topics of discussions. This type of program helped to reach out as many women as possible hence also helped reduce MCH problems because of the hard working spirit of these women counsellors who visited all women in the village whether members or non members” (FGD - 2304 - 14.09.10)*

In some cases this support took the form of funds and assistance to those affected by MCH problems.

*“Community members from one village did not attend the meeting because they were helping to take a patient to hospital. Through the groups they learnt problems that required hospital attention so when they found someone suffering they took her to hospital” (OBS - 7 - 13 - 29.08.05)*

In other cases it took the form of advice and information about these problems, their solutions and a clarification of any misconceptions.

*"[During needs assessment] the women raised problems and talked about bewitching - then through discussion some women explained that they were not really problems and also explained that they should go to hospital rather than sing'anga [witch doctor]" (OBS - 6 - 181 - 25.08.05)*

## **Participation**

In most communities identifying common problems and solutions enabled women's group members to develop an understanding of the importance of coming together to share and learn from each other and for some non-members, who initially chose not to participate in groups to change their minds and join the groups

*“Previously, when we summoned people for a MaiMwana or women's group meeting, people never attended the meetings. People thought it was useless. These days because people have talked so much about it, when a meeting is called people come in large numbers because they know and have hope that they are going to learn and share one or two things on how to improve MCH” (FGD - 2304 - 14.09.10)*

## Collective action

In most communities identifying common problems and solutions allowed women's group members to identify a common focus on which they could collectively take action in the form of locally feasible strategies.

*“What we are doing in women's groups for MCH, we identified problems in relation to MCH. We identify one problem and assess how we can solve it. If it was to do with anemia, we felt that to deal with that problem we had to start dimba cultivations. We have currently a vegetable garden. We are currently harvesting and eating to supplement irons and vitamins. This is helpful because when a mother is expectant she should not be weak in terms of nutrition” (FGD - 0206 - 30.07.10)*

The information accessed and generated through the assessment process also enabled members to influence community wide policies relating to MCH.

*“When we have the toilets we avoid the unnecessary bleeding of mosquitoes, bleeding of houseflies that can contaminate our foods. Having toilets, pit latrines and drying racks helps a lot in improving our health. We recommend each and every household to have a toilet so as to prevent other diseases such as cholera and trachoma...there is a real change...as each and every one in this community is responsible to make sure that actions are being done.” (FGD - 3802 - 09.09.10)*

Finally, they also drew on the information that arose from their discussions to implement solutions at an individual and family level.

*“I want to add on what has already been said. This assessment has helped not only the group but also our families because previously we could not know why a certain problem has come in our family and how to solve it, or what we could do. So, the needs assessment has helped not only the women's group, village or community but also our families” (FGD - 2304 - 14.09.10)*

## **7.4 The outcomes of local leadership of women's groups**

### **7.4.1 Interpersonal resources**

#### **Knowledge resources**

In most communities the direction and structure from local leaders enabled women's group members to more effectively share their knowledge and experiences and, in some communities, involved the leaders sharing their own, sometimes more developed, knowledge about these issues with other members.

*"The [ZF] who stays at Nkhwazi was the one who was teaching all these things on safe motherhood. After teaching us, then with the guidance of the chairlady, we were calling for a group discussion to share the health practices issues that [the ZF] presented to us. We were able to know why we are having different health problems both to mothers and children, and were able to contend them by having some solutions" (FGD - 1006 - 30.10.10)*

The local leaders also provided direction and structure to the wider community by sharing the knowledge they had received through the groups with non-group members.

*"I think what has changed is that in the first place, they were ignorant of the causes of maternal mortality. But after sitting down and discussing they can assess how best to prevent these deaths. They are also able to teach other community members of the dangers of infant and maternal mortality" (FGD - 1701 - 25.08.10)*

In contrast in a few other communities the lack of direction and structure from local leaders meant that women's group members were not able to effectively share their knowledge and experiences with each other.

*"Much as we said earlier on, it's difficult to say that the attitudes have changed since we were lacking the direction from our leaders through the facilitator. Had it been that they were active with us, we would have gained a lot of knowledge and skills which eventually would change our attitudes. But with the status of our non-existence, non-active group, it's hard to mention the attitude changes" (FGD - 1006 - 30.10.10)*

## **Physical resources**

In many communities the direction and structure from local leaders enabled women's group members to successfully mobilise physical resources by linking them to sources of funds and negotiating over access. They also encouraged members to donate their time and energy to MCH activities.

*"Actually, my contribution is that our leader the chairlady was really connecting the group activities with the community. She was able to call people to do some piece works which were intended to bring some financial resources to the group. She was willing to take care of the activities on MCH" (FGD - 1006 - 30.10.10)*

In contrast, in some other communities, the lack of structure and direction provided by local leaders meant community members were unsuccessful at mobilising necessary resources.

*"This was very difficult as we were lacking direction from the chairwoman who failed to bring us capacities such as human and other physical resources, that's the reason that the group stopped" (FGD - 1006 - 30.10.10)*

## **Psychological resources**

In many communities the direction and structure from local leaders changed the attitudes of women's members and they developed an increased sense of ownership of MCH issues.

*"Local leadership...develops local ownership and builds individual and community capacity to deal with problems and provides a resource to do this" (OBS - 11 - 136 - 23.11.06)*

It also developed their confidence to address these issues, especially in implementing mother and child care and care-seeking behaviours.

*"Facilitator: Why was it that previously you never sought medical care?"*

*Respondent: There were no leaders who could instill confidence in people on the importance of going to the hospital either for medical care or delivery" (FGD - 1701 - 25.08.10)*

Finally, it increased the motivation of members to address these issues by mobilising and strengthening them to act.



*“Where we were slackening, we will now be strong. Whoever was unwilling to continue, will now think twice. We were lacking leaders...to come and strengthen us as a group. We appreciate [our leaders] because frankly speaking we were relaxing and nearly collapsing” (FGD - 1701 - 25.08.10)*

#### **7.4.2 Interpersonal relationships**

##### **Networks**

In most communities the direction and structure from local leaders developed a sense of unity and cohesion between different individuals and groups to associate in ways that they had not done previously.

*“They [the leaders] brought unity in the group otherwise we could not have gathered here like this, but this is a manifestation that there is unity and cohesion amongst us” (FGD - 1701 - 25.08.10)*

Local leaders also brokered wider relationships and successfully linked women’s group members from different communities and women’s group members with external organisations.

*“Facilitator: Do you have such links or networks in your group because of your leaders?”*

*Respondent: There are such links like the one that we have established [through the leaders] with the health department at the hospital” (FGD - 1701 - 25.08.10)*

In contrast, in a few other communities, the lack of direction and structure from local leaders meant that new networks like these were not developed.

*“The reason that Mkhase has not done their dimba is that they are waiting for the ZF to contact the extension worker. Even though they knew where this person lived they had no leadership in the group to take this issue forwards. They don't have leadership because they lack the skills and abilities to lead” (OBS - 26 - 14 - 16.02.09)*

##### **Participation**

In some communities the lack of direction and structure from local leaders meant that women’s group members did not attend the groups because they were not organised sufficiently. In a few cases groups failed to increase or decreased in size and became static or disbanded.

*“Respondent 1: What happened is that when we had agreed to hold a meeting on a particular day, some of the leaders were not present on that proposed day. They raised a lot of excuses. It was either we had not set a good day or else they were busy on that day. Some of the leaders could even plead to say lets fix another day but when the day was set, you could still get the same lame excuses. When it was put up to them to propose the best day for the meeting, they could not come up with a date. So, as a result I was also tired of these excuses and I too gave up.*

*Respondent 2: I concur with my colleague to the fact that it's us the leaders that contributed to the downfall of the group. In the first place, we were not coordinating well. How do you expect people to attend to a meeting when you are actually informed of the meeting the very same day of the meeting? One did not just have to wake up one day and call for a meeting. There was need for proper planning of meetings and inform all that were involved in good time. It transpired that some people did not attend the meetings because they were already engaged on other activities” (FGD - 4104 - 23.08.10)*

### **Collective action**

In many communities the direction and structure from local leaders helped to better organise and encourage women's group members to start to collaborate and implement actions to take control of MCH. This generally took the form of collective strategies, implemented by women's groups, to prevent or manage MCH problems.

*“In the first place the changes have come about because the leaders that we chose together with the rest of the group did not take these activities on a personal level [did not work for their own personal interest]. We worked on this at a group level where everybody's participation and involvement was of a paramount importance...our local leader's involvement, has also contributed to the rapid changes in MCH activities” (FGD - 1701 - 25.08.10)*

In contrast, in a few other communities, direction and structure from local leaders was not provided and thus women's group members were not catalysed or organised to effectively take collective action to achieve their MCH objectives.

*“In fact, we had poor leadership in our group, so whatever activity that was intended to be done, was becoming a failure” (FGD - 1006 - 30.10.10)*

## **7.5 The outcomes of women's group organisational structures**

### **7.5.1 Interpersonal resources**

#### **Physical resources**

In many communities the organisation to socialise and address their concerns brought by structures enabled women's group members to mobilise the resources they needed to address their MCH problems.

*"In most cases when we are planning for any type of mobilisation, we have a [strategy committee] of two or three members that meet and raise a point or a suggestion, we discuss that within the task force, when we agree whether it is worth for us to engage in such a process, we call the whole group for scrutiny and actual implementation" (FGD - 1506 - 22.10.10)*

#### **Psychological resources**

In many communities the organisation to socialise and address their concerns brought by structures also developed the confidence and self-reliance of women's group members to address MCH issues themselves.

*"[We] do not depend on outside assistance. If for example we don't have money...the committee [organises us to] do piece works. After doing the piece work, we buy fertilizer to apply to the vegetables. We are self-reliant; we don't depend or rely on help from outside us. We grow our own crops e.g. vegetables, harvest and sell them to see what next we can do with the money. When we have enough money, we plan how to use the money. We may decide to put the money on a revolving loan scheme within the group so as to multiply the money further" (FGD - 0206 - 30.07.10)*

Furthermore, it developed their sense of strength and capability that they could address their MCH problems effectively.

*"Yes, as you know that the group needs to be cohesive for it to be as strong as possible. This zone committee acts as a pillar upon which the groups get their strengths to perform effectively" (FGD - 2301 - 03.09.10)*

## 7.5.2 Interpersonal relationships

### Networks

In most communities the organisation to socialise and address their concerns brought by structures brought different groups within communities together and united them in their efforts thus developing new networks of association between different individuals and groups within the same community.

*“The objective of this committee is to bring unity among the groups in order to reduce maternal mortality...[in the past] there was isolation like when a person was bereaved; community usually regarded that as his/her own affair. One would take responsibility of the funeral single handedly as such huge debts were created that could be difficult to pay back. The chief used to settle disputes emanating from debts due to funerals. We no longer have these cases now because through MaiMwana [women’s groups] we have learnt to work together” (FGD - 2301 - 03.09.10)*

Furthermore, it developed new networks between women’s group members in different communities and with organisations outside their communities.

*“Because of such committees even group members are united...there was no such unity before as my colleague has just said. We used to depend on what this village had, but now we also rely on friends from other villages. We can do things together with other villages - this makes us feel like children of one parent” (FGD - 0206 - 30.07.10)*

### Social support

In most communities the organisation to socialise and address their concerns brought by structures helped women’s group members to identify who was most in need and to arrange themselves to ensure that these individuals received relevant emotional, tangible and information support.

*“We help each other such that there is no isolation amongst us as it used to happen in the past. When there has been a call for assistance, the committees come to help...they borrows from [the committee] in order for us to help those who need immediate assistance” (FGD - 2301 - 03.09.10)*

## **Collective action**

In most communities the organisation to socialise and address their concerns brought by structures also helped women's group members to harness their collective potential and implement strategies to address their MCH problems.

*“In the health committee, we encourage others to clean the surroundings of our households, we ensure that there are no dams, swamps; we ensure that there are rubbish pits and that we drink safe and clean water where chemicals like water guard has been applied. This is about health committee” (FGD - 0206 - 30.07.10)*

## **7.6 The outcomes of women's group members mobilising resources**

### **7.6.1 Interpersonal resources**

#### **Knowledge, skills and physical resources**

In most communities effectively mobilising resources and using them prudently ensured that a range of physical, information and skill resources were available to women's group members and that mobilised resources were used for their intended purposes.

*“This bicycle ambulance was being used by all, whenever someone is in need of it, someone is sick; we urgently take the patient on the bicycle ambulance to the hospital” (FGD - 1506 - 22.10.10)*

In most cases it was so successful that it also ensured that members and their households experienced lower levels of resource poverty and disadvantage.

*“Let me talk about the bee keeping, we sell the honey at the markets thereby generating money into our group which we can share amongst ourselves. We can use this money to buy some of our basic household needs. In this way our poverty is being reduced, thereby improving our health status” (FGD - 1506 - 22.10.10)*

In contrast, in a few other communities, lack of effective mobilisation and prudent use of resources meant that necessary resources were not available or accessible to those who needed them.

*“Let me argue on that point about the bicycle ambulance, we are no longer supporting each other with this bicycle ambulance; it is not working right now. The bicycle is grounded. We are no longer*

*accessing the need that we prioritised...the bicycle is not working as it is lacking some spare parts like tubes; people are actually reluctant to contribute money for the purchase of other new tubes” (FGD - 1506 - 22.10.10)*

Furthermore, in these communities, the mobilised resources were not used for their intended purpose.

*"Community in zone 17 managed to get a loan but the men are using it for their own businesses. It is being misused so they will not be able to achieve their objectives" (OBS - 20 - 41 - 28.02.08)*

### **Psychological resources**

In many communities effective mobilisation and prudent use of resources also changed the attitudes women's group members and helped them develop a sense of self-reliance to address their MCH problems.

*“We are self reliant in our community, every household has something rear like pigs which are boosting their economy...our attitudes have changed as we are able to mobilise our own resources in this community. We have realized that a group is a tool that can help us achieve what we need” (FGD - 1506 - 22.10.10)*

It also developed their confidence to take control of and address these problems.

*“We are having more confidence as we are getting linked to a number of organisations, the more we are being assisted and achieve what we need, the more we are having confidence of achieving mother and child issues by mobilizing ourselves in getting the resources...our organisation is growing stronger and stronger as we are able to agree on what we needs need to be mobilised” (FGD - 1506 - 22.10.10)*

As a result, members felt less dependent on external organisations to give them resource 'handouts' and to solve their MCH problems for them.

*“We don't rely on someones else...we come together and do piece works just as my friend has said. If we have raised money, for example MK2000, we decide to buy fertilizer and pesticides. Watering cans are sourced from households. We sew the vegetables and share*

*responsibilities for watering the seeds within ourselves alternately” (FGD - 0206 - 30.07.10)*

In particular, women’s group members became less dependent on MaiMwana to help them achieve their objectives.

*“We have the skill and ability of sustainability, even if MaiMwana phases out, we will be able to sustain ourselves” (FGD - 1506 - 22.10.10)*

## **7.6.2 Interpersonal relationships**

### **Trust**

In some communities lack of effective mobilisation and particularly prudent use of resources created divisions and a lack of trust between women’s group members. As a result, they often restricted access to the resources to only individuals and groups who were deemed trustworthy.

*“We do not let non group members borrow this money as we are not sure of their trustworthy. They may fail to pay back and this may result in finger pointing amongst group members to effect that you start blaming each other that its you who brought this person to access the loan and now she or he is failing to pay back. This bickering creates divisions in the group which leads to disintegration or disorganisation because of financial mismanagement. That’s why we decided to revolve this loan amongst ourselves because we know how hard we sweat to raise the money. But as for other people we have reservations to borrow them the money because we know that we struggle to get the little that we have raised” (FGD - 0206 - 30.07.10)*

### **Reciprocity**

In most communities effective mobilisation and prudent use of resources encouraged women’s group members to enter into reciprocal relationships where resources were shared with those in need without an expectation of an immediate return.

*“The only problem that I can see with this bicycle ambulance is maintenance cost; it is actually used by all people regardless of the group membership, whom we ask to pay a little amount for using it. This money is meant at maintaining the bicycle once it is damaged. But most of them don’t pay, but we don’t push them for payments to avoid*

*pointing fingers to the group as being cruel to them. We simply use our own group resources to maintain it” (FGD - 1506 - 22.10.10)*

## **Networks**

In most communities effective mobilisation and prudent use of resources also entailed bringing different individuals and groups within communities together in new ways.

*“Our good example is this protected well. During construction, we were asking each other to come and bring sand, bricks, and then all people were coming in large numbers. This well is actually providing social support to the communities” (FGD - 1506 - 22.10.10)*

Furthermore, some resources were mobilised jointly and subsequently shared between several communities developing new networks between them.

*“All the surrounding villages were accessing this bicycle ambulance” (FGD - 1506 - 22.10.10)*

Finally, some resources were mobilised from organisations outside communities. To achieve this, new networks were developed between communities and external organisations.

*“Our organisation is growing stronger and stronger as we are able to agree on what we need to be mobilised. Our relations with other organisations have improved as we have many visitors coming to us. In the past we could run away if we see a white man coming to us, but nowadays we know that they are people as we are. We can interact and chat with them” (FGD - 1506 - 22.10.10)*

In contrast, in a few other communities, the failure to effectively mobilise resources and particularly to prudently use them fractured the networks established between women’s group members and drove them apart.

*“Misunderstandings among group members about the use of funds raised from sales of dimba produce...it has divided the group” (OBS - 16 - 71 - 07.09.07)*

## **Social support**

In most communities the effective mobilisation and prudent use of resources has provided assets that women’s group members could draw on to provide tangible support to non-members who were in need.



*“When a friend is sick, she is taken to the hospital using the bicycle ambulance. A lot of things are needed at the hospital which require money, for example, relish or soft drinks. This [mobilised] money is used for such things” (FGD - 2301 - 03.09.10)*

## **Participation**

In a many communities the effective mobilisation and prudent use of resources was visible to non-group members and attracted them to become involved in the groups so that they could gain access to the mobilised resources.

*“This can improve as will be able to mobilise funds on ourselves. If the funds are available then the committee will be empowered its activities, and many people will interested to join the group” (FGD - 2508 - 06.09.10)*

In contrast, in a few other communities, the lack of effective mobilisation and prudent use of resources led women’s group members to choose not to participate in women’s groups because they saw no benefits. In some cases women’s groups even disbanding as a result.

*“Secondly, when it was evident that we would receive a bicycle ambulance and then it transpired that the ambulance was diverted to another village that was the starting point of more problems. The women were demoralized by these incidences and felt that their efforts were put to wrong use to help other people. I for one had contributed my money towards this bicycle ambulance but this ambulance has not carried even a single patient from this village to the hospital. No woman has benefitted from this bicycle ambulance from my village. We even do not know how it looks. The only tangible benefit that these people hoped for was taken away right from their eyes. These were the reasons they lost interest and drive to continue coming together as a group” (FGD - 3302 - 24.09.10)*

## **Collective action**

In most communities, the effective mobilisation and prudent use of resources enabled women’s group members to collaboratively implement a wide range of strategies to prevent and manage their MCH problems.

*“Yes, we collectively use the group to address our health problems, we have already said that we are having problems in accessing safe drinking water; we have collectively used the group to lobby for the*

*health workers to come and address our problem by providing chlorine to treat our water” (FGD - 2505 - 13.10.10)*

## **7.7 The outcomes of women’s group members linking with other people and organisations**

### **7.7.1 Interpersonal resources**

#### **Knowledge**

In many communities partnerships, coalitions and alliances provided women’s group members with opportunities to gather information and advice and learn from their partners. This included knowledge about MCH problems, contributing factors, solutions and strategies.

*“There has been change in the sense that previously there was no safe motherhood. There was no family planning; people were giving births frequently. But through the teachings that we got from our health partners; we know that frequent deliveries wear out women’s bodies. So women have been advised to get what...what is it called...err... what...to get family planning services. This is helping our women’s group to achieve safe motherhood” (FGD - 1102 - 21.10.10)*

#### **Skills**

In many communities partnerships, coalitions and alliances provided women’s group members with opportunities to learn skills from external organisations and women’s group members in other communities.

*“We wanted to add skills on top of the skills that we already had because we thought that what we might have been doing could be different from what our friends [from other communities] were doing. We therefore thought of sharing knowledge and skills. We give them our skills and they give us what they have” (FGD - 1102 - 21.10.10)*

In some cases the members learnt skills related to mother and child care and care-seeking practices that could be directly applied to solve MCH problems or to the strategies they had identified to implement these in practice, such as skills in: small business management, agriculture, literacy, numeracy and financial management.

*“My addition is that we have got some skills from Total Land Care in manure productions, which are helpful to our crops” (FGD - 3603 - 07.10.10)*

## Physical

In most communities partnerships, coalitions and alliances enabled women's group members to gain access to a wide range of physical resources.

*"We are very thankful through the different links that have been formed. Through these links we used to get fertiliser, bicycle ambulance and some boreholes from Partners in Hope to address our water problems as we used to drink unclean water before that. From the health department we have mobilised an antenatal clinic which is functional besides the bed nets. I am very thankful for all that has happened through the partnerships that have been formed" (FGD - 1102 - 21.10.10)*

Furthermore, these links enabled members to pool relatively high cost and 'rare' resources and share access with each other.

*"There is an understanding from the chiefs and attendees that not every community can have a BA...they will ensure the ones that exist are shared and used effectively by working together" (OBS - 16 - 162 - 20.09.07)*

As a result, these links, by providing access to resources, helped to reduce the resource poverty and disadvantage experienced by members in these communities.

*"There is poverty reduction in our society as with have links with other organisations within our grouping" (FGD - 2905 - 18.10.10)*

In contrast, in a few other communities, the lack of partnerships, coalitions and alliances made it difficult for women's group members to mobilise the resources they needed.

*"We just started the meetings towards mobilizing resources when we realised that we could not do it by ourselves and decided to invite men at one of the meetings and only five turned up. Still, it was difficult for us to effectively mobilise the required resources and we gave up" (FGD - 3302 - 24.09.10)*

## Psychological

In many communities the partnerships, coalitions and alliances changed the attitudes of women's group members so that they developed a greater sense of control, confidence and self-reliance to address their MCH problems.

*“We have been empowered and enlighten us to have the sense of control by the partnership that we have formed with COMSIP. We have been empowered that we can eradicate poverty on ourselves without relying to the money lending institutions, they gave us skills of saving money in our own villages and we can share the savings and start the small scale business. In this way, we have the sense of control and feel the ownership in reducing our household poverty, and thus reducing the problems that the mothers are experiencing” (FGD - 2505 - 13.10.10)*

It also helped them to develop a greater sense of joint ownership, with their partners, over these problems.

*“Yes, we feel the ownership of the health concerns, whenever we meet and discuss the activities to do we also involve the other stakeholders of the community to assist us in achieving what we want, so we easily take control of the MCH activities” (FGD - 2905 - 18.10.10)*

They also developed an increased sense of responsibility to address MCH problems themselves.

*“I am very grateful for this discussion and would want to say that we have experienced many changes here; so many things have changed since we formed partnerships with other groups through MaiMwana Project. The chief as well as everybody is taking responsibility in order to help expectant women and children to grow well and health. As a result of this, the partnerships that we have formed are very reliable and effective. We are working very hard towards sustaining these links and probably form other new links so that we can share the knowledge and skills that we have gained from the existing partnerships” (FGD - 1102 - 21.10.10)*

Finally, they changed women’s group members perceptions towards traditional and cultural practices. In particular the links, with men in communities, allowed them to discuss MCH issues more openly and increased male involvement in MCH and women’s involvement in decision-making.

*“The other thing that changed is the attitude of secrecy. Because women used to stay away from men, it was difficult for them to tell a man or husband whether they felt sick or how sick they were in respect of tradition. These days, they immediately report of any maternal*

*problems they have to their husbands and it is the responsibility of the husband to give the necessary assistance to the woman. This is another attitude that has changed...there was an attitude of secrecy in the past where maternal issues could not be discussed with men but these days maternal issues are openly discussed with our husbands” (FGD - 1102 - 21.10.10)*

### **7.7.2 Interpersonal relationships**

#### **Trust**

In a few communities the partnerships, coalitions and alliances for shared goals developed a sense of trust between women’s group members.

*“We are sharing the health resources with our friends from Dikirani, it means we are working to achieve the common goal, we trust each other in all the activities that we are doing (FGD - 2505 - 13.10.10)*

Furthermore, they helped to develop a sense of trust between women’s group members and external organisations such as health facilities.

*“We are now advantaged that we are going to the hospitals without fear, in the past we were thinking that the hospital is only meant for those that are in the towns or trading centre. We are now going there without fear and intimidation [because of our links with them]; they are helping us at will’ (FGD - 1506 - 22.10.10)*

#### **Reciprocity**

In a few communities the partnerships, coalitions and alliances developed the sense of reciprocity and sharing of resources between women’s group members and with non-members.

*"Group needs bricks for khola [animal enclosure]. An individual in the village has already got some bricks so the group negotiated to use them in the short-term. But in the long-term they will mould and fire bricks and give them back to the individual" (OBS - 18 - 193 - 15.11.07)*

#### **Networks**

In many communities partnerships, coalitions and alliances formed the basis of new networks of association between people in the same community.

*“It is true that in the past we used to be independent on MCH issues while these days we depend on each other. We help each other on the group whenever problems arise” (FGD - 1102 - 21.10.10)*

In other cases these networks were formed between women's group members in different communities.

*“We have improved social networks in assessing causing factors of MCH problems in our area and beyond, we have made networks with many groups that for many times have been inviting us to participate in their group activities and meetings thereby sharing knowledge and experiences. Many groups are interested to work with us, as they have realized that we are hard - working and result oriented group. We are receiving a lot of groups to learn from us. Chakhala village is a role model in MCH issues in our area and beyond” (FGD - 3603 - 07.10.10)*

Finally, these networks were also formed between women's group members and external organisations.

*“We have developed a partnership with the health workers at the District Hospital that provided us with mosquito nets...we were sharing the responsibilities of our MCH needs with our partners, for example when we were prioritising our needs about malaria we were doing that in collaboration with the health workers as we were aware and assured that they will supply us with mosquito nets. In the process there was another problem that was cordially identified by the health workers and us about diarrhea in mothers and the under five children, they started providing us with chlorine for water protection.” (FGD - 2505 - 13.10.10)*

### **Social support**

In most communities partnerships, coalitions and alliances allowed women's group members to support each other and to support non-members. Furthermore, they allowed external organisations to support women's group members through information and advice or tangible assistance, such as physical resources or assistance to address MCH problems.

*“Since all the groups and villages surrounding this area are dependent on one another, once we have a problem, we liaise with our different partners and we really get what we want, in so doing there is no*

*isolation, we are depending on each other on different activities” (FGD - 2505 - 13.10.10)*

In some cases the support provided through these partnerships also included emotional support for people suffering from MCH problems.

*“We help each other on different problems be it at funerals, sicknesses. The group takes responsibility either by contributing money or maize towards a funeral or any other problem. This strengthens the relationship between the women’s group members and other groups including the chief because we are doing one and the same thing” (FGD - 1102 - 21.10.10)*

### **Participation**

In a few communities, through the partnerships, coalitions and alliances, women’s group members have managed to encourage other community members to participate in their activities.

*“The extension worker from World Vision is encouraging women in his catchment area to attend meetings. He is a partner, feels it is important and understands the aims and objectives very well” (OBS - 7 - 24 - 08.09.05)*

### **Collective action**

In most communities partnerships, coalitions and alliances enabled women’s group members to work together to implement strategies to solve their MCH problems.

*"Lubaini have finished moulding bricks and are ready to fire them. At the same time members of the Village Health Committee (which works hand in hand with the women’s group and shares members with the women’s group) came to Kapiri to get quotes for door frames. Therefore, the groups are working together to achieve a common goal" (OBS - 17 - 20 - 26.09.07)*

In other cases these links between women’s groups in different communities have enabled members to collaborate on area level strategies to solve these problems.

*“We have improved community interactions as we are able to organise joint meetings with out friends from Dikirani Village. We are working together on common objectives” (FGD - 2505 - 13.10.10)*

Finally, these between women's group members and external organisations have also enabled them to work together to implement strategies to solve their MCH problems.

*"This partnership was established with the purpose of having a strong working relationship in order to achieve our objectives as a unit...a person alone cannot achieve anything meaningful unless you work together. This is why we thought of linking with others like the chief, Partners in Hope so that together we can achieve something" (FGD - 1102 - 21.10.10)*

The partnerships, coalitions and alliances with others have also enabled women's group members to influence community and higher level MCH policies, such as advocating for changes in the services offered by local health services.

*"This can be easily described in the sense that we have managed to talk with health partners about the under five mobile clinic, we had long distances to walk to Kaigwazanga Health Centre for under five clinic. We asked them to bring this clinic here at Langa, to ease transport problems, it really happened because we are having a good level of partnership" (FGD - 2505 - 13.10.10)*

And advocating for improvements in the health services being offered.

"HSAs are feeling odd because in the past they could do what they wanted (or not do anything!) but now relationship with groups makes them accountable. Women's groups are coming to them and asking for things which changes the dynamic and empowers communities over HSAs to some extent" (OBS - 14 - 96 - 09.03.07)

And successfully advocating for changes in the loan policies of lending institutions.

"Total Land Care usually charges a deposit of Malawi Kwacha (MK) 1500 per person for each treadle pump. However, groups / committees lobbied Total Land Care and this has now been changed to MK 1500 per group which will be much more possible. Groups have managed to change the policy of this partner" (OBS - 20 - 137 - 09.04.08)

Finally, these partnerships, coalitions and alliances have also allowed women's group members to become leaders in MCH in their communities.



*“There is a difference between a group and the village or a community. As a women’s group, we can call for a village meeting through the chief and share with the people various issues on MCH. This may also include recommendation on the need for expectant mothers to go to the hospital in time” (FGD - 1102 - 21.10.10)*

## **7.8 The outcomes of women’s group members asking why**

### **7.8.1 Interpersonal resources**

#### **Knowledge resources**

In a few communities critical consciousness of root causes and actions to address these raised the awareness of women’s group members of the root social, economic and cultural causes which underpin the ill health of mothers and children. For example, the members identified poverty and illiteracy as key factors underpinning poor MCH.

*“The base of malaria is poverty...the other factor that was influencing malaria was poverty, if you don’t have money to buy mosquito nets; you are likely to get malaria attacks which can eventually lead to asphyxia and unconsciousness. This poverty was another factor that was making many women to deliver at the TBAs as at the hospital they have a number of requirements for delivery like the razor blade, plastic sheeting and basins” (FGD - 3603 - 07.10.10)*

It also raised the awareness of members that the MCH problems were not simply due to the choices made by individuals but also patterned by the socio-environmental context in which they lived.

*“So much so that you now know that a particular problem has not come because of a person x for example but has come because of this or that reason” (FGD - 3703 - 16.09.10)*

It also helped members to design solutions to help address these root causes and strategies to help implement these solutions in practice.

*“We started this adult literacy school after realizing that most of us are illiterate. We were unable to read and write. We wanted to overcome this problem in our community. After establishing this adult school we have managed to organise ourselves in village savings and loans, since we are able to read and write...I should say that the coming of this*

*adult literacy school has helped us to know how to read and write. The illiterate people were the ones that were making development not to prosper in our community. This school has changed people's knowledge and skills; they know what is good to do" (FGD - 3603 - 07.10.10)*

Beyond solutions and strategies, becoming critically conscious raised the awareness of women's group members about the health rights of women and children.

*"In frankly speaking, women would easily realize that they are now tired of delivery, they may tell this to their husbands but men couldn't accept it. But with the advices that this women group has been giving to men, they are now aware that a woman need to rest after a couple of some children deliveries. They understand this concept" (FGD - 3802 - 09.09.10)*

And it also made them aware of their individual responsibilities in relation to these MCH rights.

*"To combat this problem we agreed during the assessment that everyone should be responsible of making his/her surrounding clean, especially during the rainy season that we are approaching when malaria becomes quite a problem. The main thing is that all bushes surrounding our houses should be cleared. All swamps and pools around our houses should be filled or covered with earth to prevent mosquitoes from breeding in such places. This is what we have been teaching each other to reduce malaria cases in this community" (FGD - 2304 - 14.09.10)*

Finally, it also made them aware of the responsibilities of others relation to MCH such as men and health workers.

*"The HSA is a drunk and doesn't do his job. The group went to the health facility to negotiate for a new HSA to be posted. Concern that the HSA will not do his job so Florida and the community trying to negotiate to have him replaced" (OBS - 13 - 88 - 18.12.06)*

### **Skills resources**

In a few communities the critical consciousness of the root causes and actions to address these helped to develop the skills of women's group members to implement solutions to address them. For example, business skills, literacy and numeracy skills.

*“There is an impact in the health of mother and children, with the coming of the adult literacy school in our area, it has helped many to read what has been written on their health passports. They are able to read the prescriptions; this is improving the health status of our community. In the past people would take medicines anyhow that’s causing other health problems” (FGD - 3603 - 07.10.10)*

### **Psychological resources**

In some communities critical consciousness of the root causes and actions to address these changed the attitudes women’s group members such as increasing their sense of confidence to address their MCH problems.

*“We are able to know and understand the root causes of MCH problems and we are acting on getting the solutions in time...we are confident in establishing our own health problems by conducting surveillances within our community and we are confident with the solutions that we make” (FGD - 3603 - 07.10.10)*

It also changed their perceptions towards some traditional and cultural practices including increasing the levels of male involvement in MCH issues and addressing social norms around gender roles to enable women to take more control over their lives and the lives of their children.

*“There is a change as mothers can stand on their own in some economic issues. Women are able to access some loans enabling them to do some small-scale businesses; they can generate some income that can support their families economically” (FGD - 3603 - 07.10.10)*

## **7.8.2 Interpersonal relationships**

### **Networks**

In some communities the critical consciousness of the root causes and actions to address these helped women’s group members to identify which individuals, groups and organisations they should link with to address their concerns and encouraged them to form these relationships.

*“I want to add that before we linked with the health department, we had frequent deaths amongst us. But we sat down to assess the causes of the deaths and realised that we needed the services, and knowledge of the health experts to come and teach us how to take care of our food,*

*general hygiene and sanitation including antenatal and postnatal services to reduce mortality” (FGD - 1102 - 21.10.10)*

### **Collective action**

In a few communities critical consciousness of root causes and actions to address these formed the basis for the development of collective action to address the underlying causes of their MCH problems.

*“Our commitment has changed, at first we were wondering on what we will be getting from MaiMwana looking at its project approach and strategy, when we started being in the groups with our facilitator, assessing our needs and root causes, it’s when we have realized that the surveillances that we were doing are bearing fruits. The community is coming together to act on the MCH issues” (FGD - 3603 - 07.10.10)*

This action generally took the form of strategies to solve MCH problems, such as strategies to reduce poverty.

*“We discovered that malnutrition is a result of poor diet so we thought that it would be better if a person is involved in some small income generating businesses to have some money to supplement the diet. One way was to encourage each one of us to have a dimba where we could freely access vegetables and sell the surplus to buy some other necessities” (FGD - 3703 - 16.09.10)*

It also included strategies to improve literacy.

*“This [literacy] school has changed many things in our lives, as I have already mentioned that we were unable to read and write. We were not able to read what the health workers have written in our health passports. Even if we talk about getting the right amount of change when buying goods from the local markets, we were being cheated by the traders by giving us less change. Imagine you are buying goods worth K200.00 and you have given out K500.00, but you are being told that there is no change. We are able to read by ourselves the destination of the buses in the bus depots, before this school we were asking to know where the bus is going” (FGD - 3603 - 07.10.10)*

Finally, strategies to address the disadvantage of women's group members in information about MCH issues. This included: establishing a district radio programme concerned with MCH, members actively sharing information with those who lacked it and lobbying for HSAs to be posted to their communities.

Critical consciousness of the root causes and actions to address these also stimulated collective advocacy selecting changes and improvements in local community policies and services.

*"MaiMwana also taught us to be open enough on maternal issues. Most of what we do involve women going to the hospital unfortunately these women come across hostile situations there and they come back to us as local leaders to report the hostilities. We then report these issues to MaiMwana leaders so that they come with us and talk to the hospital staff on their verbal aggression to women so that these women do not shun the hospitals" (FGD - 2902 - 05.11.10)*

This advocacy has also extended to seeking changes in some national policies.

*"Malewa group recorded grievances with Mudzi Wathu Community Radio Station. Group headman and group leaders spoke of bed nets in particular. The government has now changed the policy - we want even the president to hear our problems" (OBS - 16 - 29 - 03.09.07)*

Finally, in these communities it also stimulated women's group members to take increasing responsibility to lead their communities in relation to MCH issues.

*"The public governance have really changed in our area, in the past we were only following the directive from the chief and other leaders, but nowadays we have the decentralization, the community is more powerful in making health decisions. Whatever the community agrees, it is implemented in this area. The chiefs just make sure that we are following what we have agreed" (FGD - 3603 - 07.10.10)*

## **7.9 The outcomes of equitable relationships between women's group members and the external agent**

### **7.9.1 Interpersonal resources**

#### **Knowledge resources**

In most communities the transfer of power to women's group members raised their awareness of MCH problems, the contributing factors, solutions and strategies. It also raised their awareness of how to organise themselves and manage the women's group programme.

*"Yes, as already mentioned, the external agent is the main party that gives out things that we can see with our eyes and we use them in different implementations, and it shares us with knowledge that we put into use, once we are implementing all the techniques that the external agent has direct us to do in MCH" (FGD - 0205 - 03.11.10)*

#### **Skills resources**

In many communities the transfer of power to women's group members also developed their organisational skills, skills in identifying and solving MCH problems and technical skills to implement strategies to improve MCH.

*"Yes, just as we have being saying of the dimba cultivation and the bicycle ambulance operation that we have in our group, also we have the abilities of doing small scale business...to reduce the economic problems that we have in our community" (FGD - 0205 - 03.11.10)*

#### **Physical resources**

In most communities the transfer of power to women's group members also enabled them to mobilise resources that they needed to address their problems.

*"MaiMwana Project helps us in so many ways in this village. For example the organisation helps us in mobilizing our needs in the sense that whenever we require any assistance be it a loan or otherwise, they do not hesitate to help us. We know that these days one cannot exist in isolation but needs to link with others like MaiMwana Project that helps us a great deal. When we need a loan facility, we ask them to help us and they do. These loans have helped us improve our livelihoods because we have cash at hand through the businesses that we do that help us generate income" (FGD - 2902 - 05.11.10)*

## **Psychological resources**

In some communities the transfer of power to women's group members changed their attitudes including making them feel more competent and confident about MCH issues.

*"What I can partially remember is that MaiMwana Project built capacities in us in safe motherhood, in MCH...we have the confidence in doing things and achieve the results and also sustain them" (FGD - 0205 - 03.11.10)*

It also made them feel that in the future they could work independently of MaiMwana Project to achieve their aims and objectives.

*"MaiMwana Project has built independent spirit...they empower group leaders to feel they can guide and facilitate the group and women should feel what they are doing is for themselves" (OBS - 12 - 46 - 22.09.06)*

It also encouraged them to feel that they were responsible for addressing MCH issues rather than being reliant on others to do it for them.

*"Its unfortunate that people say that because the [ZF] is there to guide and direct us on MCH. That she has a responsibility over our lives as well as our children's in trying to reduce mortality. Those who say that only lack knowledge and understanding" (FGD - 4104 - 23.08.10)*

Finally, it changed their perceptions about certain traditional care and care-seeking practices. For example, they encouraged them to choose to deliver at health facilities rather than at TBAs.

*"In terms of maternity, things have changed because after getting the advice and counsel from MaiMwana Project, we follow and practice what we are taught. People never knew of family planning and hospital delivery. Many people relied on traditional medicine but people have now known the importance of these things. At least we have lesser maternal problems and mortality as compared to the past" (FGD - 2902 - 05.11.10)*

It also encouraged them to consider that women should be treated more equally and with greater respect.

*"People for example used to marry a brother's wife in the event that the brother has passed on in a system known as 'chokolo / kulowetsa fisi'*

*which have since been stopped due to the good counsel from MaiMwana Project” (FGD - 2902 - 05.11.10)*

Furthermore, that men should have greater involvement in MCH issues.

*“Another change is that MaiMwana Project has empowered men to get involved in maternal issues. We do this by encouraging our wives to go to the hospitals whenever they are sick or have maternal problems as well as taking children to the hospital when sick. We have also known the importance of openly going for VCT as a family” (FGD - 2902 - 05.11.10)*

In contrast, in a few other communities, the lack of transfer of power to women’s group members meant they did not discover a sense of competence and confidence to take control of their MCH issues.

*“Mkhase dimba had not moved forwards because the group replied that they were waiting for the ZF to contact the agriculture extension worker on their behalf...until this is done for them they did not feel they could go any further” (OBS - 26 - 13 - 16.02.09)*

In these communities the members became dependent on the external agent to achieve their aims and objectives.

*“Some groups not solving their own problems but relying on ZF, FTO, SFTO, Technical Advisor to do so - they are building dependence” (OBS - 20 - 62 - 04.03.08)*

## **7.9.2 Interpersonal relationships**

### **Collective action**

In most communities the transfer of power to women’s group members enabled them to take collective advocacy to seek improvements in services, such as those offered by health facilities.

*“MaiMwana Project also taught us to be open enough on maternal issues. Most of what we do involve women going to the hospital unfortunately these women come across hostile situations there and they come back to us as local leaders to report the hostilities. We then report these issues to MaiMwana Project leaders so that they come with us and talk to the hospital staff on their verbal aggression to*



*women so that these women do not shun the hospitals...we are open to talk to MaiMwana Project leaders who in turn talk to hospital staff on general good behaviour so that women should not be afraid to go to the hospital for delivery and be intimidated by the doctors or nurses...I think that previously people were shy to ask for things that would benefit them unlike these days when we are free to go and meet health officials and ask for assistance as it is required be it outbreak of diarrhea or otherwise” (FGD - 2902 - 05.11.10)*

It also encouraged members to take increasing responsibility to guide their communities in MCH issues.

*“Yes, especially when the group village headman or the local leader has called for a meeting; we as women’s group are empowered to address the community on MCH issues pertaining to what problems we have at that particular time. As such, we feel that we are able to influence mother and child activities” (FGD - 2902 - 05.11.10)*

## **7.10 The outcomes of women’s group members controlling programme management**

### **7.10.1 Interpersonal resources**

#### **Psychological resources**

In many communities taking control of decision-making changed the attitudes of women’s group members and made them feel more competent and confident in managing the women’s group programme and ultimately their entire communities to address MCH problems.

*“We have the capacities in managing this group and even the whole community to mobilise different resources through different means [to address MCH problems]...We have the positive attitude in managing our MCH activities in our area as we are able to achieve a lot in all the activities that we are undertaking. Whenever you succeed in managing something, it gives you some confidence that one day you will be able to manage something at a higher level” (FGD - 2403 - 29.10.10)*

Members also developed a sense that they could work independently of the external agent to achieve their aims and objectives.

"We will be able to conduct meetings in the future...even when the project is not here. We will conduct meetings in the future and share knowledge and experiences" (OBS - 7 - 30 - 08.09.05)

Finally, they developed a sense of ownership of the programme and its aims and objectives.

*"As already mentioned earlier on, we plan our activities through the participatory group meetings, we make sure that these meetings are frequently done for continuity. These continuous meetings promote the spirit of unity, coordination and feeling the ownership of our own health problems...we always know that once a child is sick to malaria or a mother is having frequent malaria attacks while pregnant, this will lead to anemia problems to them, and all these problems will still be in our hands, we feel all the health problems that affect us are really our own" (FGD - 2403 - 29.10.10)*

#### **7.10.2 Interpersonal relationships**

##### **Collective action**

In most communities the control over decision-making enabled women's group members to become involved in decision-making about MCH issues at the community level.

*"Another change in public governance in MCH activities in this community is that all women are working closer with the local leaders like the chiefs. In the past women would have something to do in addressing mother problems in this community but they were turned back as the chiefs were feeling more superior to whatever was happening in this community, nowadays women's groups are working hand in hand with the chiefs. The chiefs are coming to the group to work and collaborate together in all MCH activities. This is a positive change of public governance in managing MCH problems" (FGD - 2403 - 29.10.10)*

#### **7.11 Summary**

Table 7a (page 297) presents a summary of the outcomes for women's group members in many communities where they succeeded in organising and mobilising themselves to take action to improve MCH.

The findings show that in most communities, the progress from individuals concerned about MCH, and acting alone, through increasingly organised and mobilised groupings, to

communities acting collectively to redress the deeper underlying causes of these issues generates a wide range of personal and interpersonal resources that the community members can draw on to take action to bring about the desired changes. Where individual community members may lack the necessary resources and thus struggle to bring about these changes, their involvement in groups, community organisations and partnerships appear to release, to them, the resources they need to take the required social and political action.

The findings show that in most communities, the increasing organisation and mobilisation of community members pools and helps to develop a wide range of personal resources that become accessible to them to take action. The findings show that small mutual groups and community organisations are particularly good fora for the exchange of ideas and experiences which help to develop the knowledge and skills of community members in MCH issues and the skills needed to address them. The findings also show that partnerships are particularly good for enabling community members to identify and mobilise the resources they need to take action to address their MCH issues. Finally, the findings show that the increase in knowledge, skills and resources, brought about by greater organisation and mobilisation, are associated with a change in attitudes and increased motivation and confidence amongst community members to take action to address the MCH issues facing them.

The findings also show that in most communities, the increasing organisation and mobilisation of community members pools existing and helps to develop new inter-personal resources help them to take action to address MCH concerns. The findings show that small mutual groups and community organisations bring people together and formalise their association and thus are particularly good for generating trust and reciprocity between community members. They also provide a forum for the development and sharing of informational, tangible and emotional support. The findings also show that partnerships help to develop more diverse, inclusive and flexible networks within and between communities and between communities and external organisations. Finally, the findings show that the increases in trust, reciprocity and support and the development of more extensive networks, brought about by greater organisation and mobilisation, are associated with an increase in instances of collective social and political action by community members to address the MCH issues facing them.

Furthermore, table 7b (page 298) presents a summary of the outcomes missing for women's group members in some communities where they failed to organise and mobilise themselves to take action to improve MCH.

The findings show that in some communities, the lack of organisation and mobilisation of community members failed to release all the personal resources that they needed to take action to address their MCH concerns. The findings show that the lack of effectively organised small mutual groups and community organisations meant the absence of a fora through which

community members could exchange ideas and experiences and thus develop their knowledge and skills in MCH issues and skills needed to address MCH them. The findings also show that the lack of effectively organised partnerships meant community members were not able to identify and mobilise the resources they need to take action to address their MCH issues. Finally, the findings show that since community members lacked adequate knowledge, skills and resources they also lacked the motivation and confidence to take action to address the MCH issues facing them.

The findings also show that in some communities, the lack of organisation and mobilisation of community members failed to release the inter-personal resources they needed to take action to address their MCH concerns. The findings show that the lack of effectively organised small mutual groups and community organisations meant that community members were not brought together in formal associations and thus did not have the appropriate opportunities to develop trust and reciprocity. Their absence also failed to provide a forum for the development and sharing of informational, tangible and emotional support. The findings also show that the lack of effectively organised partnerships meant that networks remained small and did not extend within and between communities and between communities and external organisations. Finally, the findings show that in the absence of trust, reciprocity and support and extensive networks, community members did not receive the encouragement or support necessary for them to undertake collective social and political action to address the MCH issues facing them.

*Table 7a: Summary of outcomes for women's group members in many communities where they succeeded in organising and mobilising themselves to take action to improve MCH*

<p>Improved knowledge of:</p> <ul style="list-style-type: none"> <li>• MCH problems.</li> <li>• factors that contribute to MCH problem.</li> <li>• solutions to MCH problems.</li> <li>• strategies to implement solutions to MCH problems in practice.</li> <li>• gaps in MCH knowledge that needed to be filled</li> <li>• root social, economic and cultural causes which underpin poor MCH.</li> <li>• the fact that MCH problems are not simply due to choices made by individuals but also patterned by socio-environmental context</li> <li>• actions to address the root causes of the poor MCH.</li> <li>• health rights of women and children.</li> <li>• individual responsibilities to MCH.</li> <li>• Improved knowledge of responsibilities of others to MCH.</li> <li>• organisation and women's group programme management.</li> </ul>
<p>Increased skills in:</p> <ul style="list-style-type: none"> <li>• technical aspects of strategies to solve MCH problems.</li> <li>• community organising.</li> <li>• group working.</li> <li>• identifying MCH problems.</li> <li>• solving MCH problems.</li> <li>• safe-motherhood and child health care practices.</li> <li>• women's group programme management.</li> </ul>
<p>Increased physical resources:</p> <ul style="list-style-type: none"> <li>• funds and other resources including those needed for implementing strategies to solve MCH problems in practice.</li> <li>• used for intended purpose.</li> </ul>
<p>Developed psychological resources:</p> <ul style="list-style-type: none"> <li>• control over MCH problems.</li> <li>• capability to address MCH problems.</li> <li>• self-reliance to address MCH problems.</li> <li>• mastery over MCH problems.</li> <li>• strength to address MCH problems.</li> <li>• motivation to address MCH problems.</li> <li>• individual and collective responsibility to address MCH problems.</li> <li>• ownership of MCH problems.</li> <li>• ownership over women's group programme.</li> <li>• independence from others, including the external agent, to address MCH problems.</li> <li>• change in traditional MCH care and care-seeking practices.</li> <li>• change in cultural norms regarding gender and sexual and reproductive health.</li> <li>• change in perceptions of health services.</li> </ul>
<p>Increased trust between:</p> <ul style="list-style-type: none"> <li>• community members within the same community.</li> <li>• community members in different communities.</li> <li>• community members and outside organisations.</li> </ul>
<p>Increased reciprocity between:</p> <ul style="list-style-type: none"> <li>• community members within the same community.</li> <li>• community members in different communities.</li> </ul>
<p>Development of new networks between:</p> <ul style="list-style-type: none"> <li>• community members within the same community.</li> <li>• community members in different communities</li> <li>• community members and external organisations.</li> </ul>
<p>Provision of information and advice, tangible support and assistance and emotional support:</p> <ul style="list-style-type: none"> <li>• between women's group members.</li> <li>• between women's group members and non-members.</li> </ul>
<p>Increased participation in:</p> <ul style="list-style-type: none"> <li>• women's groups.</li> <li>• other mother and child health activities.</li> </ul>
<p>Engagement in collective action:</p> <ul style="list-style-type: none"> <li>• in the form of strategies implement solutions to MCH problems in practice including those to address the root causes of MCH problems.</li> <li>• to advocate for changes in local and national mother and child health policies.</li> <li>• to advocate for changes in services offered and improvements to services.</li> <li>• to take control of community MCH governance.</li> </ul>

*Table 7b: Summary of the outcomes missing for women's group members in some communities where they failed to organise and mobilise themselves to take action to improve MCH*

<p>Lack of improvement of knowledge of:</p> <ul style="list-style-type: none"> <li>• MCH problems, contributing factors, solutions and strategies.</li> </ul>
<p>Lack of improvement of skills in:</p> <ul style="list-style-type: none"> <li>• MCH problems, contributing factors, solutions and strategies.</li> </ul>
<p>Lack of increased physical resources:</p> <ul style="list-style-type: none"> <li>• resources to implement strategies in practice.</li> <li>• resources to address their concerns.</li> </ul>
<p>Lack of development of psychological resources:</p> <ul style="list-style-type: none"> <li>• no sense of competence.</li> <li>• no sense of confidence.</li> <li>• no sense of control.</li> <li>• dependence on external agent.</li> </ul>
<p>Lack of increase in trust between:</p> <ul style="list-style-type: none"> <li>• community members within the same community.</li> <li>• community members in different communities.</li> <li>• community members and external organisations.</li> </ul>
<p>Reduced participation in:</p> <ul style="list-style-type: none"> <li>• women's groups.</li> <li>• other MCH activities.</li> </ul>
<p>Failure to engage in collective action:</p> <ul style="list-style-type: none"> <li>• in the form of strategies implement solutions to MCH problems in practice including those to address the root causes of MCH problems.</li> </ul>

## **Chapter 8: Discussion**

### **8.1 Key findings**

The findings of this thesis show that through the MaiMwana women's group intervention women's group members built their capacities to become more organised and mobilised to take action to improve MCH and reduce mortality, which in turn generated a range of interpersonal elements (figure 8a - page 300).

Key capacities of community members built by the intervention included (figure 8a: column 1 - page 300): increased knowledge and improved skills to organise and mobilise themselves to take control of the social determinants of MCH, and adequate opportunities to do so (figure 8a: column 3 - page 300) and changed the attitudes of community members towards organising and mobilising themselves to take action to improve MCH and reduce mortality (figure 8a: column 3 - page 300).

Community members became more organised and mobilised by using these capacities to (figure 8a: column 5 - page 300): come together with others in similar circumstances, identify common MCH concerns and solutions, provide direction and structure, organise themselves to socialise and address their broader concerns, access resources and use them prudently, develop partnerships, coalitions and alliances, raise their critical consciousness of the root causes of MCH problems and solutions to address these, become empowered to take control of the women's group programme and take control of decision-making of the women's group programme.

Interpersonal elements generated as community members became organised and mobilised included (figure 8a: column 7 - page 300): collective resources (increased knowledge, improved skills and increased physical and psychological resources) and improved relationships (increased trust and reciprocity, new networks of association, improved social support and participation in MCH activities and engagement in collective action).

Given these findings, in this chapter, I argue that the socio-environmental mechanism through which the MaiMwana women's group intervention reduces maternal and child mortality is as follows: through the activities of the MaiMwana women's group intervention women's group members build their capacities to become more organised and mobilised, empowering them to harness the interpersonal elements that arise from this process and bring them to bear on the social determinants of MCH through individual, organisational and community action.





## **8.2 Limitations of the thesis**

Efforts, described in chapter 4, were taken to help ensure the credibility, auditability and fittingness of the findings of this thesis. Despite these efforts some limitations still existed in the theory and conceptualisation of the thesis, the research strategy and the data quality.

### **8.2.1 Theoretical and conceptual limitations**

The ways in which community mobilisation through women's groups addresses the SDH can be accepted to be dynamic and complicated. Taking account of all this complexity in a description of the mechanism is not only beyond the scope of this thesis but also runs the risk of helping to obscure rather than helping to reveal how community mobilisation through women's groups actually works. As a result, drawing on the realist literature, the mechanism in this thesis has been conceptualised and presented as a linear process starting with activities, moving through immediate, intermediate and long-term outcomes and ending with impacts. In the future, building on this linear interpretation, additional research needs to be undertaken to tease out the complexities of this mechanism in more depth and to help develop a more dynamic and realistic interpretation.

### **8.2.2 Limitations of the research strategy**

The mechanism through which community mobilisation through women's groups works does not operate in a vacuum. The activities, the immediate, intermediate and long-term outcomes and the impacts of the intervention are all influenced by the context in which the intervention is operating. Indeed, different mechanisms, consisting of different activities, outcomes and impacts, are triggered in different contexts. Taking account of context could thus help to develop a range of different mechanisms through which community mobilisation through women's groups works. Describing such a broad range of mechanisms is not only beyond the scope of this thesis but also, as discussed above runs the risk of helping to obscure how community mobilisation through women's groups actually works. As a result, this thesis did not collect information about the context in which the intervention was operating and did not attempt to describe all the mechanisms that were triggered. Instead, by collecting information from as many of the groups as possible, it sought to describe an 'average' mechanism in operation across all contexts. This was thought to be a particularly sound approach as data collected through the MaiMwana randomised controlled trial suggests that except for a few extreme cases the majority of contexts in which women's groups were operating were relatively homogenous. In the future, building on this 'average' mechanism, additional research needs to be undertaken to describe the extreme contexts in which the intervention is operating, and how these influence activities, outcomes and impacts. This would help to better describe the range of mechanisms triggered.

### **8.2.3 Limitations of data quality**

The selection of respondents for the FGDs may have affected the quality of data collected. First, the selection of women's group communities from which respondents were drawn involved consulting the ZFs, FTOs and SFTO to identify pools of communities that they felt expressed good and poor characteristics on the nine domains of community empowerment. As a result, this selection was based on a subjective assessment and may have been biased by relationships and experiences in these communities rather than solely the characteristics of these communities on the nine domains. In retrospect, based on the findings of this thesis, a more objective way to categorise communities could have been developed that would allow a more impartial selection of communities from which to draw respondents for FGDs.

Second, the selection of the individual FGD respondents, within the communities identified, was carried out by the chairpeople of the women's groups in those communities. As a result, although they were guided to select respondents from certain groups within the community, they did not select them at random and thus this selection was based on their subjective decisions and may have been biased by their relationships and experiences with the community members. In retrospect, the selection of community members to act as respondents in FGDs could have been carried out more randomly to minimise any potential bias.

Much of the data for this thesis was collected through non-participant observation of women's group meetings. At the beginning of the thesis the data collected in this way may have been of poorer quality for two main reasons. First, the observer (MR) was male and from outside Malawi and this may have influenced the behaviours of the women's group members. Second, the Chichewa language skills of the observer meant that some discussions may have been missed or misinterpreted. However, these observations took place over a five and half year period. As a result, these limitations became much less pronounced as in this time the women's group members came to know the observer very well and he became much more fluent in Chichewa. In retrospect, to minimise the initial problems, a local woman could have been recruited and trained as a research assistant to conduct the non-participant observation.

Finally, the participant and non-participant observation generated a large amount of data (over 6000 pages of field notes). This affected the length of time taken to analyse the data and, since categories became over saturated, also how long it took to write up the findings. In retrospect, a more careful consideration of the saturation of categories could have helped to reduce the amount of observation data collected and thus simplify data analysis and write up.

## **8.3 What the findings mean**

### **8.3.1 The MaiMwana women's group intervention empowers individuals, organisations and communities to take action to improve MCH and reduce mortality**

The findings suggest that the MaiMwana women's group intervention enabled women's group members to organise and mobilise themselves to take action to improve MCH and reduce mortality. Given these findings there is reason to argue that by organising and mobilising communities women's group members in this way the MaiMwana women's group intervention empowered individuals, organisations and communities to take action to improve MCH and reduce mortality (figure 8b - page 310). Other studies of similar interventions have shown similar success of community mobilisation in organising individuals, organisations and communities to take action to address the SDH. The Ekjut intervention in India succeeded in bringing about reductions in neonatal mortality which were hypothesised to come through the development of critical consciousness of root causes of ill health amongst community members and their capacity and confidence to take action to challenge actors responsible for perpetuating them (Rath et al, 2010). Furthermore, the Sonagachi intervention in India built the capacity of impoverished and excluded sex workers to take control of their sexual health (Evans and Lambert, 2008). Finally, the Entabeni intervention in South Africa failed to achieve its objectives because it did not adequately build the capacities of poor rural women to take control and deliver effective HIV/AIDS care (Campbell and Cornish, 2010a).

#### **Empowering individuals for the development of small mutual groups**

The findings show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of community members to participate in women's groups (chapter 6 and figure 8a: column 3 - page 300) and that participating in women's groups organised and mobilised them by bringing them together with others who shared similar MCH concerns (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also organise and mobilise community members in this way; they also brought community members together with others who shared similar concerns. (Ilika and Ilika, 2005; Blankenship et al, 2010; Dong et al, 2010; Rath et al, 2010; Campbell and Cornish, 2010).

Laverack (2004; 2005) describes how coming together with others sharing similar concerns empowers community members by enabling them to better define, analyse and, with the support of others, act on their concerns and achieve their goals. Rifkin and Kagere (2001) found similar benefits to participation and highlighted that participation can increase the commitment of community members to the actions taken.

The findings also describe the quality of participation of women's group members (chapter 5 and figure 8a: column 3 - page 300) and suggest that through participation women's group members developed their capabilities, became more involved in activities that influenced their lives and health and raised their critical awareness. Rifkin and Kagere (2001) agree that participation can help community members to develop their skills, knowledge and experiences. Laverack (2004; 2005) goes further to suggest that it is these outcomes of participation that help to empower community members by developing their political concerns and catalysing them to take personal action to address these concerns.

As a result, there is reason to argue that by bringing people together the MaiMwana women's group intervention empowers individuals to take action to improve MCH and reduce mortality.

The findings show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members to assess their problems (chapter 6 and figure 8a: column 3 - page 300) and that assessing their problems organised and mobilised them through the identification of common concerns, solutions and actions (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also organise and mobilise community members in this way; they also enabled community members to identify common concerns, solutions and actions (Ilika and Ilika, 2005; Blankenship et al, 2010; Rath et al, 2010).

Identifying common concerns and solutions encouraged community members in Mchinji to form small groups around these common issues and Laverack (2004; 2005) suggests that through the support of small groups community members have become empowered as they are enabled to find a 'voice' and to participate more formally in actions to address their concerns.

The findings also describe the process of problem assessment by women's group members (chapter 5 and figure 8a: column 3 - page 300) and show that the assessment of problems and solutions was generally carried out by the women's group members themselves, that the views and opinions of a wide range of other non-members were also gathered and considered and that the external agent did not impose its knowledge or opinions over these views but instead facilitated the process of problem and solution assessment by strengthening the skills and handing over the responsibility to them to make their own assessment. Indeed, the process included the use of methodologies, such as PRA, which were evolved specifically for this purpose (Marsden, Oakley and Pratt, 1994). Laverack (2004; 2005) posits that assessing needs and solutions in these ways helps to ensure that the common concerns and solutions identified accurately reflect the needs of community members and generates a sense of ownership of the problems and solutions. This, in turn, empowers members by increasing their commitment to work together in small mutual groups to take action to address their concerns. The importance of problem assessment towards community empowerment has also been identified in a number

of other health programmes (Tonon, 1980; Pelletier and Jonsson, 1994; Plough and Olafson, 1994; Purdey et al, 1994; Roberts, 1997). For example, Pelletier and Jonsson (1994) found that involving community members in Tanzania in assessing their problems motivated them to take action and provided a basis for maintaining accountability for taking action.

As a result, there is reason to argue that by enabling people to identify common concerns, solutions and actions the MaiMwana women's group intervention empowers groups to take action to improve MCH and reduce mortality.

### **Empowering groups for the development of community organisations**

The findings show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members to become local leaders and develop organisational structures (chapter 6 and figure 8a: column 3 - page 300). These provided direction and structure and organised them to socialise and address their broader concerns (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also organise and mobilise community members in these ways; they also provided direction and structures to socialise and address their broader concerns (Ilika and Ilika, 2005; Dong et al, 2010; Blankenship et al, 2010; Rath et al, 2010; Campbell and Cornish, 2010).

The findings also show that community members identified and appointed their own leaders (chapter 5 and figure 8a: column 3 - page 300). Rifkin (1990) and Goodman (1998) suggests that this can avoid a situation where historically or culturally determined leaders take control and exclude marginalised groups by representing only the elite. Furthermore, the findings show that the external agent built the leadership skills and capacities of community members to become local leaders. Rifkin (1990) and Goodman (1998) discuss how developing local leaders in these ways helps to empower community organisations by providing effective direction to plan and take action to address the concerns of their members. Indeed, Gruber and Trickett (1987) suggest that the absence of a leaders will result in community organisations that are disorganised and Costantino-David (1995) has shown that poor leaders limit the ability of community organisations to take action.

The findings also show that developing organisational structures allowed women's group members to come together to interact and connect and to identify and find solutions to their problems (chapter 5 and figure 8a: column 3 - page 300). Laverack (2004; 2005) posits that interacting in these ways empowers community organisations by allowing them to more effectively take action to resolve the problems of their members.

As a result, there is reason to argue that the MaiMwana Project women's group intervention empowers groups to take action to improve MCH and reduce mortality by providing direction and structure and organisation to socialise and address broader concerns.

### **Empowering community organisations to develop partnerships**

The findings show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members to access resources and link with other people and organisations (chapter 6 and figure 8a: column 3 - page 300). These enabled them to access resources and to form partnerships, coalitions and alliances with others based on shared goals (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also organise and mobilise community members in these ways; they also provided access to resources (Ilika and Ilika, 2005; Dong et al, 2010; Rath et al, 2010; Campbell and Cornish, 2010) and enabled community members to form partnerships, coalitions and alliances (Ilika and Ilika, 2005; Blankenship et al, 2010; Rath et al, 2010; Campbell and Cornish, 2010).

The findings also show that women's group members were successful in mobilising a wide range of resources (chapter 5 and figure 8a: column 3 - page 300), an ability which Goodman (1998) cites as an indication of a high degree of skill and organisation. Furthermore, the findings show that external agents assisted women's group members to mobilise resources by linking them to potential donors and developing their skills to identify, mobilise and access the resources they needed. Laverack states (2004; 2005) that the presence of necessary resources can empower community organisations by providing them with the means to take action to address the concerns of their members. This is supported by evidence from a number of other programmes, which have also identified the ability of community organisations to mobilise resources as a key factor towards community empowerment (McCall, 1988; Barrig, 1990; Eisen, 1994; MacCallan and Narayan, 1994; Fawcett et al, 1995; Hildebrandt, 1996; Roberts, 1997). For example, Roberts (1997) shows that resources mobilised by community organisations in Fiji facilitated communal action to address their concerns.

As a result, there is reason to argue that the MaiMwana Project women's group intervention empowers groups to take action to improve MCH and reduce mortality by enabling them to access necessary resources.

The findings show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members to link with other people and organisations (chapter 6 and figure 8a: column 3 - page 300) and enabled them to form partnerships, coalitions and alliances with others based on shared goals (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also organise and mobilise community members in this

way; they also enabled community members to form partnerships, coalitions and alliances (Ilika and Ilika, 2005; Blankenship et al, 2010; Rath et al, 2010; Campbell and Cornish, 2010).

Laverack (2004; 2005) suggests that partnerships, coalitions and alliances formed as community organisations link with other groups sharing similar concerns empowers them to influence broader decision-making by enabling them to take 'higher level' action (Laverack, 2004; 2005). Fawcett et al (1995) agreed, suggesting that partnerships catalyse community empowerment by allowing community members to take action to effect change in the broader policies and practices that influence their lives.

The findings also show that the partnerships, coalitions and alliances formed allowed women's group members to network with others, collaborate and cooperate in joint ventures, mobilise resources and advocate for policy change (chapter 5 and figure 8a: column 3 - page 300). Furthermore, the data shows that the external agent had a key role in brokering the links formed. Laverack (2004; 2005) suggests that forming partnerships, coalitions and alliances in these ways, and the networks and resources mobilised through them, empower community partnerships to take action to address the concerns of their members. O'Gorman (1995) found this to be the case in Brazil where community partnerships were able to exert greater pressure on the government and facilitated the sharing of necessary resources between members.

As a result, there is reason to argue that by developing partnerships, coalitions and alliances with other people and organisations the MaiMwana women's group intervention empowers groups to take action to improve MCH and reduce mortality.

### **Empowering communities to take social and political action**

Gaining power to influence the SDH involves communities struggling to change those already holding power (Laverack, 2004; 2005). These people are unlikely to change if the action is taken by individuals on their own or in small groups. They are also unlikely to change if the action only takes the form of mainstream forms of lobbying through community organisations and partnerships. Change requires social and political action by whole communities.

This action can take two forms. It can take the form of forcing the more powerful to negotiate terms with the less, but increasingly, empowered (Laverack, 2004). Alternatively, other theories stress the intersubjective character of power in collective action (Stewart, 2001). In these conceptualisations the disempowered gain power by taking action collectively rather than by taking action to wrest power from others (Wartenberg, 1992). "Here the paradigm case is not one of command, but one of enablement in which a disorganised and unfocussed group acquires an identity and resolve to act" (Luttrell et al, 2007). This may still generate tensions amongst those who feel their interests are threatened but does not involve direct action to specifically exploit these tensions.

As discussed above, the findings show that the actions of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members in multiple community empowerment domains (chapter 6 and figure 8a: column 3 - page 300) and that these capacities allowed them to organise themselves by coming together, identifying common concerns, providing direction and structure, organising them to socialise and address their broader concerns, accessing resources and using them prudently (chapter 5 and figure 8a: column 5 - page 300).

The findings also show that the activities of the intervention (chapter 4 and figure 8a: column 1 - page 300) built the capacities of women's group members to ask why they experienced their health problems (chapter 6 and figure 8a: column 3 - page 300). These enabled them to develop critical consciousness of the root causes of their MCH problems and actions to address these problems (chapter 5 and figure 8a: column 5 - page 300). Evidence, presented in chapter 3, shows that other similar community mobilisation interventions also develop critical consciousness (Ilika and Ilika, 2005; Rath et al, 2010).

The findings show that women's group members engaged in a process of critical reflection and were successful in identifying the contextual causes of their disempowerment and developing strategies to bring about change using this knowledge (chapter 5 and figure 8a: column 3 - page 300). Furthermore, the findings show that the external agents helped women's group members to identify the root causes of their MCH problems and action to address them by promoting their critical awareness through a cycle of action, reflection and action. Laverack (2004; 2005) suggests that this process of critical reflection empowers community organisations by catalysing and enabling them to take action to address the concerns of their members. The Freirian approach used by the women's groups has been used in other programmes to empower communities (Wallerstein, 1992; Wallerstein and Sanchez-Merki, 1994). For example, Wallerstein and Sanchez-Merki (1994) show how an alcohol and substance abuse prevention programme for adolescents in New Mexico, based on Freirian praxis, developed a sense of empowerment amongst individuals and communities that they could make a difference in their worlds.

In summary, Laverack (2004; 2005) posits that structure, functional leadership and the ability to mobilise resources allows small mutual groups to grow into community organisations and partnerships that, through the development of critical consciousness, become empowered by focusing on the environment that creates the needs of their members and offering the means for them to take social and political action together to address them.

The findings also show that this organisation and mobilisation empowered communities to actually take social and political action to address their concerns (chapter 7 and figure 8a: column 7 - page 300). For example, in line with the two forms of action presented above, in

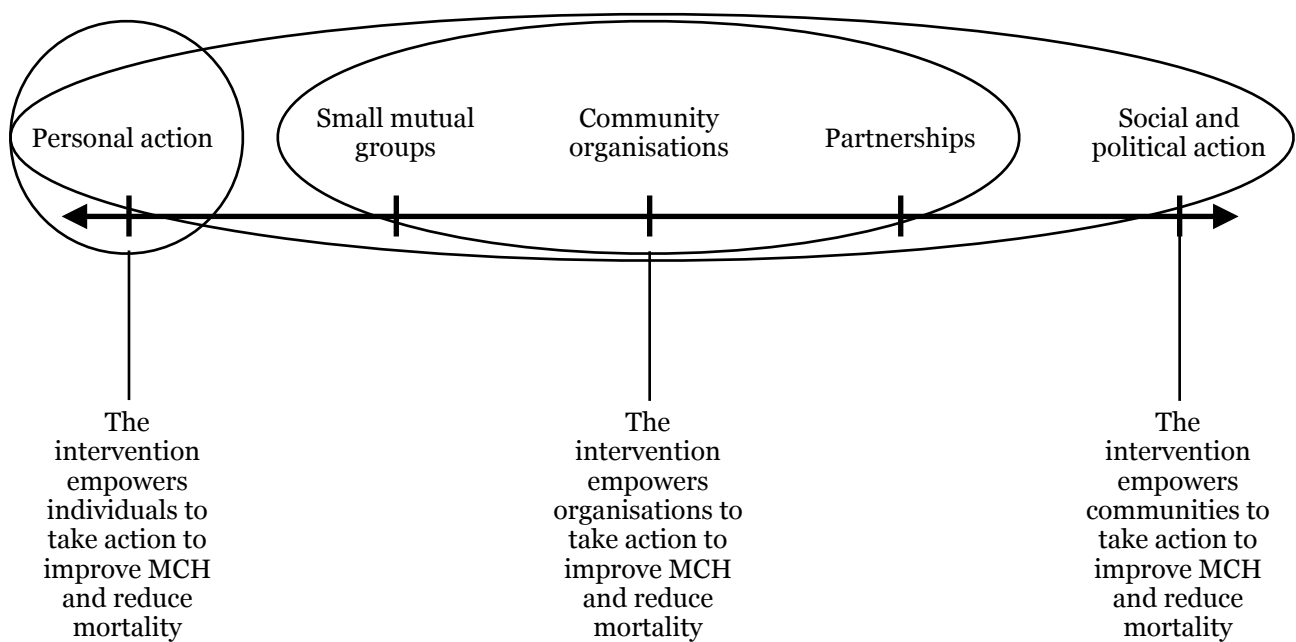


some cases communities took direct social and political action to address their concerns by challenging those with power over them and the circumstances that arose from this disempowerment, while in others, communities took collective action that did not necessarily directly challenge others. Laverack and Whipple (2010) and Boseley (2006) report similar actions resulting from a similar process of organisation and mobilisation of sex workers in New Zealand and women with breast cancer in the UK respectively. Sex workers took social and political action challenging the New Zealand government in an attempt to reform the legislation regulating the sex work industry in New Zealand (Laverack and Whipple, 2010). Furthermore, women with breast cancer took action against a Primary Care Trust in an attempt to ensure access to Herceptin cancer treatment (Boseley, 2006).

The findings also show that the external agent enabled and supported communities to take social and political action (chapter 5 and figure 8a: column 5 - page 300). They did this, often at the request of the communities, by building the capacities of individuals, groups and communities in multiple community empowerment domains, providing them with resources and technical support and encouraging them to participate in taking action to address their concerns. Beyond the findings of the thesis it is also clear that the external agent was an advocate for the communities and continuously challenged those with power over them to hand it over. These roles are precisely those used to describe a 'professional empowering relationship' (Robertson and Minkler, 1994). In such a relationship practitioners are enablers who use their power-over the community (a set of social relationships where one party is made to do what the other party wishes) to build the power-from-within of the community (gaining a sense of control over one's life) (Starhawk, 1990; Rissel, 1994). This transformative process has been described as power-with (a set of social relationships where power-over is used to deliberately increase other people's power-from-within, rather than to dominate or exploit) (Wartenberg, 1990).

As a result, there is reason to argue that the MaiMwana Project women's group intervention empowers community members to take social and political action to improve MCH and reduce mortality by bringing people together, enabling them to identify common concerns, providing them with direction and structure, organising them to socialise and address broader concerns, facilitating access to resources and developing critical consciousness of the root causes and actions to address them. There is also reason to argue that this is facilitated by the external agent transferring power to community members to take control of the women's group programme and their health.

*Figure 8b: The community empowerment continuum highlighting the individual, organisational and community empowerment dimensions of community empowerment*



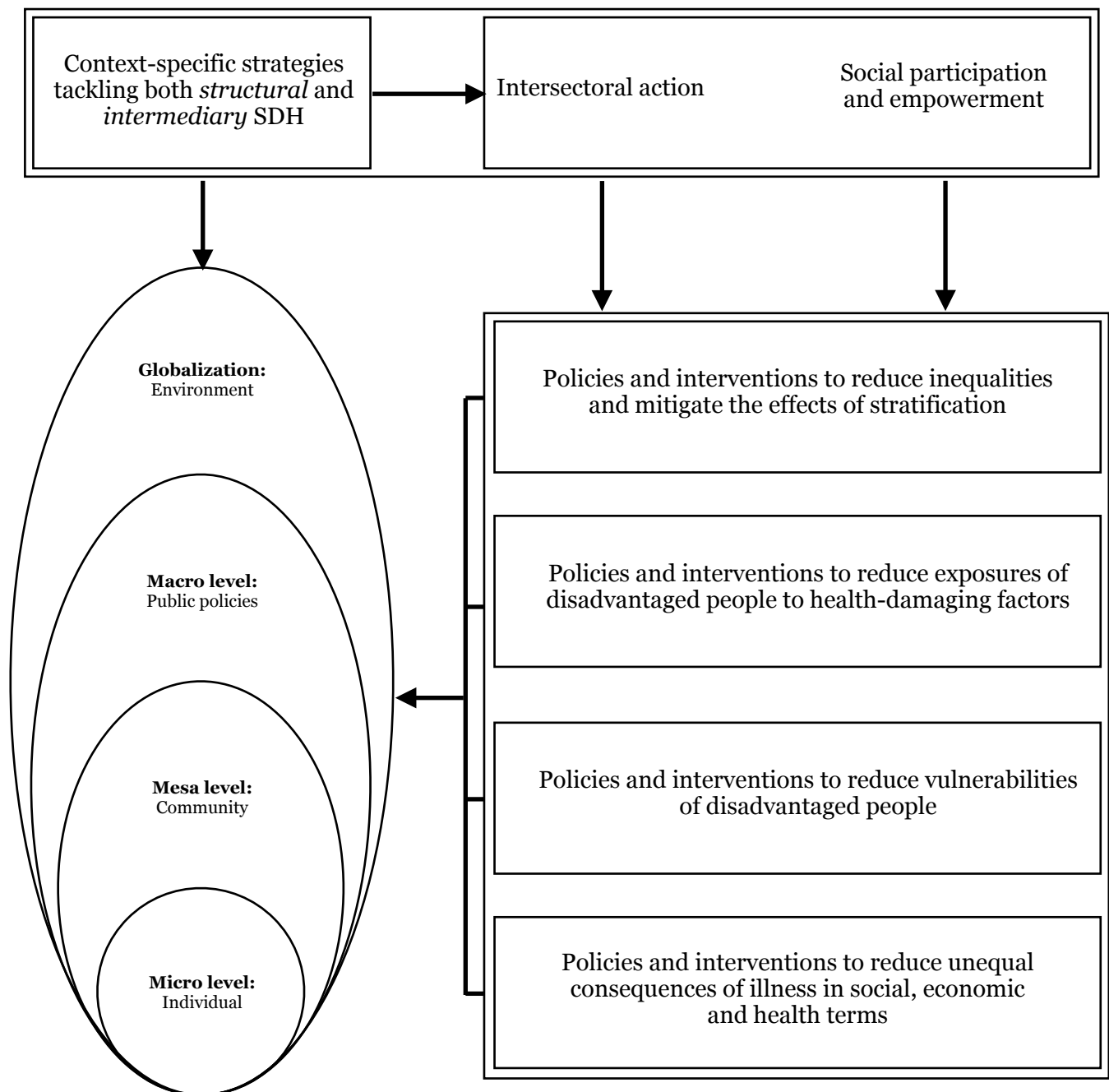
### **8.3.2 The MaiMwana women's group intervention empowers women's group members to harness the interpersonal elements that arise as they become organised and mobilised and bring them to bear on the social determinants of MCH through individual, organisational and community action**

The guiding ethical principle for addressing the SDH is 'health equity' (Solar and Irwin, 2010). This is the absence of unfair and avoidable or remediable differences in health among social groups (Solar and Irwin, 2006). Realising health equity requires the empowerment of deprived communities to exercise the greatest possible control over the factors that determine their health (Yamin, 1996).

Three broad approaches to reducing health inequalities have been proposed: targeted programmes for disadvantaged populations, closing health gaps between worse-off and better-off groups and addressing the social health gradient across the whole population. An equity based approach to addressing the SDH must ultimately focus on gradients across whole populations (Towsend et al, 1990). Indeed improving the health of poor groups and narrowing health gaps, although important, are alone insufficient (Graham and Kelly, 2004).

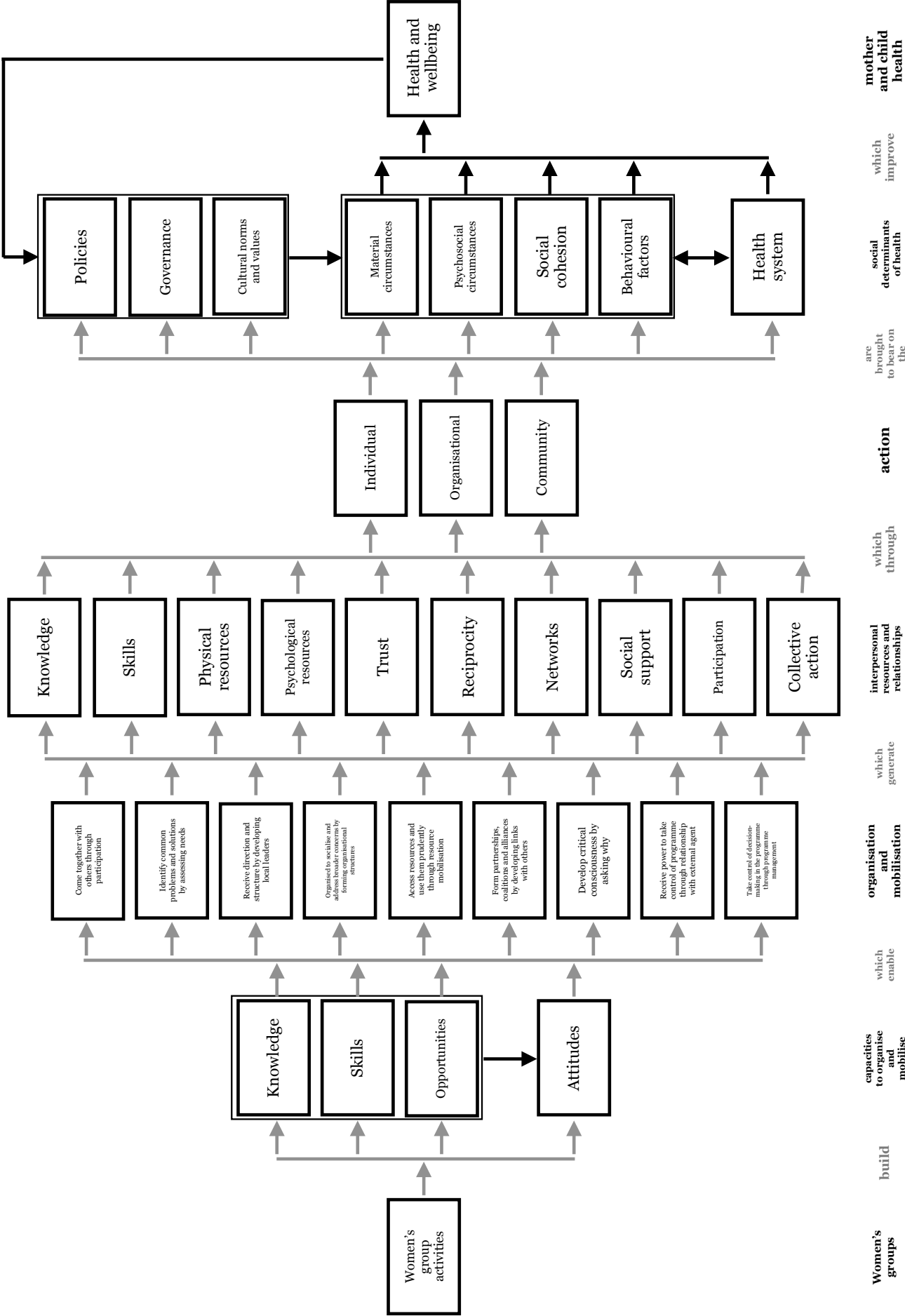
A gradients model locates the cause of inequalities not only in the disadvantaged circumstances and health inequalities of the poorest groups, but also in the life chances, living standards and lifestyles associated with people's unequal positions in the socioeconomic hierarchy (Graham and Kelly, 2004). Policy development frameworks, applied to the gradients model, help to identify suitable levels of intervention and entry points for action on the SDH. The frameworks of Stronks (2002) and Diderichsen et al (2001) suggest interventions and policies ranging from those tackling underlying structural determinants to approaches focussed on the health system and reducing inequalities in the consequences of ill health suffered by different social groups (Solar and Irwin, 2010). Solar and Irwin (2010) drew on these to identify the fundamental directions for policies and interventions to reduce health inequalities. These should involve context specific strategies tackling structural and intermediary determinants, intersectoral action and social participation and empowerment (figure 8c - page 312).

Figure 8c: Framework for tackling the social determinants of health inequalities (adapted from Solar and Irwin, 2010)



In the discussion above it is argued that organising and mobilising women's group members empowered individuals, organisations and communities to take social and political action to improve MCH and reduce mortality. The findings show that as women's group members became increasingly organised and mobilised to take social and political action to improve MCH and reduce mortality a range of interpersonal resources and relationships were generated (chapter 7 and figure 8a: column 7 - page 300). Considering these findings there is reason to argue that the action taken included women's group members harnessing the interpersonal elements generated and bringing them to bear on the social determinants of MCH through individual, organisational and community action (figure 8d - page 314). More specifically that the MaiMwana women's group intervention empowered individuals, organisations and communities to tackle both the structural and intermediary SDH. That the intervention utilised various entry points and levels of engagement from those downstream concerned with the unequal consequences of illness to structural approaches concerned with the stratification of society. Finally, that the intervention targeted the 'micro' level of individual interactions, the 'meso' level of community conditions and the 'macro level' of public policies.

Figure 8d: The socio-environmental mechanism through which the MaiMwana women’s group intervention improve MCH and reduces mortality



Comparisons will be made with Sonagachi, Entabeni and Ekjut projects which, as discussed in chapter 2, are similar forms of community mobilisation interventions to the MaiMwana women's group intervention and, as discussed in chapter 3, gathered at least some information on the socio-environmental mechanism through which they might influence the SDH. Comparison with these studies provides support for the findings and interpretations of this thesis. Comparisons with studies of the Sonagachi and Entabeni projects are most instructive as similar to the MaiMwana women's group intervention these interventions seek to build the capacity or 'voice' of poor people to challenge the unequal social relations placing their health at risk (Campbell and Cornish, 2010a). In other words they seek to build a health-enabling social environment. However, direct comparisons are difficult due to the different conceptual models employed in exploring how these interventions work, the limited nature of these studies, the ways in which they were conducted and the fact that they did not specifically attempt to construct the socio-environmental mechanism through which the interventions operated.

### **Structural SDH**

The three key structural SDH are policies, governance and cultural and social norms and values (figure 1f - page 34).

Policies include the macroeconomic, social and public policies which generate, configure and maintain social hierarchies, and thus people's health opportunities (Solar and Irwin, 2010). The findings show that as women's group members became more organised and mobilised this generated collective actions undertaken to advocate for changes in predominantly local, but also national, public health policies (chapter 7 and figure 8a: column 7 - page 300). For example, the MaiMwana women's group intervention supported communities to undertake collective advocacy such as direct action seeking to change national policies relating to ITN distribution. The findings also show that collective action was undertaken to advocate for changes in local social policies (chapter 7 and figure 8a: column 7 - page 300). For example, the MaiMwana women's group intervention supported communities to undertake collective action such as lobbying to bring about changes in loan policies of local lending institutions.

Studies of similar interventions have a similar influence on national policies. Campbell and Cornish (2010a) state that the Sonagachi intervention impacts on HIV / AIDS policy. The Indian government HIV/AIDS programme, NACP III, explicitly mentions the Sonagachi model as its inspiration, establishing community mobilisation as a required component of HIV/AIDS intervention programmes (NACO, 2006). Furthermore, the sex workers in the project succeeded in persuading officials to register their cooperative bank despite concerns that sex workers were not 'of good moral standing' – a legal criterion for groups to register a cooperative (Campbell and Cornish, 2010a).

Governance comprises the mechanisms and processes for citizens and groups to articulate their interests, mediate their differences and exercise their legal rights and obligations (Solar and Irwin, 2010). The findings show that as women's group members became more organised and mobilised this generated actions undertaken by women's group members to take increasing leadership of community level decision-making regarding MCH (chapter 7 and figure 8a: column 7 - page 300). For example, the MaiMwana women's group intervention supported women's group members to participate and take the lead in community level MCH decision-making.

In a programme context the findings also show that psychological resources were developed and collective actions undertaken by women's group members to manage the women's group programme (chapter 7 and figure 8a: column 7 - page 300). For example, the intervention supported members to develop a sense of ownership of the programme and independence from MaiMwana Project which helped them to take control of the programme. Another example is that the intervention supported members to collectively implement strategies to solve MCH problems.

Studies of similar interventions have shown similar influence on governance at a local and programme level. For example, the Sonagachi intervention succeeded in gradually involving women in organisational decision-making and leadership while the Entabeni intervention was not able to achieve the same (Campbell and Cornish, 2010a). Another example is that the Ekjut intervention encourages local women to become increasingly active advocates for health in their communities and, in a programme context, actively involved in planning and implementing the women's groups (Rath et al, 2010).

Cultural and social norms and values comprise the biases, norms and values in society including the value placed on health, the extent to which health is seen as a collective social effort, gender biases and traditional expectations. The findings show that as women's group members became more organised and mobilised this generated changes in the cultural norms and traditional practices in communities and collective action undertaken to redress cultural biases (chapter 7 and figure 8a: column 7 - page 300). For example, the MaiMwana women's group intervention supported communities to change their cultural norms including non-discrimination of women in decision-making about issues that affect them, open discussions about maternal, child and reproductive health issues and male involvement in MCH issues. Another example is that the MaiMwana women's group intervention supported women's group members to collectively implement strategies to address their literacy and other factors leading to their disempowerment.

Studies of similar interventions have shown a similar influence on cultural norms and values. These studies suggest that the Sonagachi intervention managed to redefine prostitution as



legitimate economic activity - 'sex work' - and the sex workers' struggle as a collective one (Jana et al, 2004; Cornish, 2006). On the other hand the Entabeni intervention was not able to change the stigmatisation of AIDS as immoral and shameful, the dismissal of caring for the sick as low value 'women's work' and the stigmatisation of volunteer work as holding little dignity (Campbell and Cornish, 2010a). Furthermore, this project failed to dislodge strong traditional resistance to female leadership (Campbell and Cornish, 2010b).

As a result, given these findings there is reason to argue that the women's group intervention improves MCH and reduces mortality by empowering women's group members to harness the interpersonal resources and relationships that arose as they became more organised and mobilised and take individual, organisational and community action to bring them to bear on the policies, governance and cultural norms and values determining their MCH. By addressing these structural SDH the intervention may be improving the socioeconomic position of community members, which in turn may be reducing their exposure and vulnerability to health-compromising conditions; it may be generating a health enabling social environment.

### **Intermediary social determinants of MCH**

Five key intermediary SDH are material circumstances, behavioural factors, psychosocial circumstances social cohesion and the health system itself (figure 1f - page 34).

Material circumstances include determinants such as housing, consumption potential and the physical working and neighbourhood environments (Solar and Irwin, 2010). The findings show that as women's group members became more organised and mobilised this generated physical resources and collective strategies to address MCH problems (chapter 7 and figure 8a: column 7 - page 300). These have the potential to improve the material circumstances in which people are living. For example, the MaiMwana women's group intervention supported the generation of funds to reduce the poverty and increase the potential for members to buy health improving assets and improve their living conditions. Another example is that the intervention supported communities to undertake collective IGAs. A final example is that the intervention supported communities to undertake other collective strategies, such as building of pit latrines and clearing of household surroundings, which were targeted at reducing the presence of environmental risk factors in communities.

Studies of similar interventions have shown a similar influence on the material circumstances of community members. These studies suggest that the Sonagachi intervention contributes to the economic empowerment of community members by providing payments and access to savings and micro-credit schemes (Campbell and Cornish, 2010a). The Ekjut intervention also succeeded in mobilising resources and garnering support from the wider community (Rath et al, 2010). On the other hand the Entabeni intervention failed to secure payments for community volunteers (Campbell and Cornish, 2010b).

Behavioural factors include lifestyles or behaviours that protect or damage health (Solar and Irwin, 2010). The findings show that as women's group members became more organised and mobilised this generated increased knowledge, skills, physical and psychological resources and collective strategies to implement solutions to MCH problems in practice (chapter 7 and figure 8a: column 7 - page 300). These have the potential to support protective behaviours or prevent health damaging behaviours. For example, the MaiMwana women's group intervention increased the knowledge of women's group members of the behavioural factors contributing to MCH problems and skills and resources to implement strategies to address these factors changing their mother and child care and care-seeking behaviours. An increase in knowledge, skills and resources has a particular potential to change behaviour where women's group members also have the attitudes, such as the motivation or negative perceptions towards health damaging traditional care and care-seeking practices, to do so. The intervention also developed these attitudes. A final example is that the intervention supported communities to undertake collective strategies, such as bicycle ambulances, targeted at supporting community members to engage in protective behaviours.

Studies of similar interventions have shown a similar influence on the behavioural factors facing community members. The study of the Ekjut intervention shows that tools, such as picture cards, and participatory methods, such as story telling, helped to develop the knowledge and skills of community members about problems, causes and prevention (Rath et al, 2010). The same study suggests that the intervention also developed the concern and confidence of community members to change their behaviours and prevent MCH problems from arising (Rath et al, 2010). Furthermore, both the Sonagachi and Entabeni projects were observed to increase the knowledge and skills of community members about HIV transmission, prevention and care (Campbell and Cornish, 2010a; Campbell et al, 2007).

An individual's socio-economic position influences their exposure to experiences and life situations that are perceived as threatening, frightening or difficult to cope with - psychosocial circumstances. Psychosocial circumstances include psychosocial stressors and stressful living circumstances (Solar and Irwin, 2010). The findings show that as women's group members became more organised and mobilised this generated psychological resources for and the social support between community members (chapter 7 and figure 8a: column 7 - page 300). I These have the potential to mediate the psychosocial circumstances experienced by women's group members. For example, the MaiMwana women's group intervention supported members to develop an increased sense of control and strength, capability and mastery and self reliance and independence in relation to MCH problems which are essential for individuals to cope with the stressful situations in which they live. Another example is that the intervention developed the social support between members, such as advice, physical assistance and emotional support, which is essential to decrease isolation and exclusion and enable coping with the stressful situations in which they live.

Studies of similar interventions have shown a similar influence on the psychosocial circumstances of community members. The study of the Ekjut intervention suggests that the intervention built the sense of capacity and confidence of community members to address their MCH issues (Rath et al, 2010).

Social cohesion is related to the concept of social capital. Social capital is a key factor in shaping population health (Kawachi et al, 1997; Putnam, 2000; 2001; Popay, 2000). The most common approach to characterise and analyse social capital is the 'communitarian approach', which defines it as a psychosocial mechanism consisting of 'features of social organisation, such as networks, norms and social trust, that facilitate coordination and cooperation for mutual benefit' (Putnam, 2000). As a result, social capital is viewed as an extension of social relationships and norms of reciprocity and influences health through the social support mechanisms that these relationships provide to those who participate in them (Popay, 2000). Social capital, defined in this way as a feature of social organisation, has been distinguished into three types. Bonding social capital refers to the trust and cooperation between members of a network who share their social identity (Szreter and Woolcock, 2004). Bridging social capital refers to respectful and mutual relationships between individuals and groups who do not possess the same characteristics (Szreter and Woolcock, 2004). Finally, linkage social capital refers to respectful and trusting relationships between individuals, groups, networks and institutions from different positions on gradients of institutionalised power (Szreter and Woolcock, 2004; Putnam, 2001).

The findings show that as women's group members became more organised and mobilised this generated trust, reciprocity, and networks between women's group members and others and the participation of members in MCH activities - in other words it developed social capital in communities (chapter 7 and figure 8a: column 7 - page 300). This has the potential to improve social cohesion. For example, the MaiMwana women's group intervention increased the trust, reciprocity and networks established between community members within communities, between community members in different communities and between community members and outside organisations - in other words it increased the bonding, bridging and linkage social capital available to community members. Another example is that the intervention increased the participation of women's group members in MCH activities.

Studies of similar interventions have shown a similar influence on social cohesion. These studies suggest that both the Sonagachi and, to a lesser extent, Entabeni interventions managed to build 'bridging' and 'linkage' social capital through supportive relationships with other groups and organisations (Campbell and Cornish, 2010a). The study of the Ekjut intervention also suggests that it improved social cohesion by bringing community members together to form relationships to work on MCH issues (Rath et al, 2010).

The access to and the quality of health services have the potential to influence health by mediating exposures, vulnerability and consequences of illness (Diderichsen et al, 2001). The findings show that as women's group members became more organised and mobilised this generated psychological resources and collective actions by women's group members to advocate for increased provision of and improvement in health services (chapter 7 and figure 8a: column 7 - page 300). These have the potential to increase the access of community members to health services and the quality of the services they receive. For example, the MaiMwana women's group intervention improved the perceptions of women's group members towards health services, which are essential to increase the demand for health services amongst members. Another example is that the intervention supported collective advocacy, such as that seeking to improve the attitudes of health workers towards community members, to improve accessibility of health services.

Studies of similar interventions have shown a similar influence on access to and quality of services. The study of the Ekjut intervention shows that the women's groups began to engage in discussions with health workers about their entitlements to health services to improve the services offered (Rath et al, 2010). This study states that community members came to demand services from health workers (Rath et al, 2010). The Sonagachi project succeeded in improving the services offered by a number of powerful individuals, institutions and organisations. In particular the sex workers managed to make the police more willing to take their complaints seriously and to not abuse them (Campbell and Cornish, 2010a). Furthermore, it established its own parallel mainstream services, including clinics, ensuring respect and equal treatment from doctors, nurses, clinic staff (Campbell and Cornish, 2010a).

As a result, given these findings there is reason to argue that the women's group intervention improved MCH and reduced mortality by empowering women's group members to harness the interpersonal resources and relationships that arose as they became more organised and mobilised and take individual, organisational and community action to bring them to bear on the material circumstances, behavioural factors, psychosocial circumstances social cohesion and the health system determining their MCH. By addressing these intermediary SDH the intervention may have succeeded in reducing their exposure and vulnerability to health-compromising conditions; it may have generated a health enabling social environment.

### **8.3.3 Critique of the nine domains model of community empowerment**

This thesis, in independently developing a theory of operation grounded in data and finding that it resonates very clearly with the nine domains model posited by Laverack, provides another independent verification of this model (Laverack, 1999). However, in also understanding that the theory developed is limited by not exploring context, it also raises questions about the same absence of context in the nine domains model. It suggests that the model could more faithfully explain the community empowerment process if contextual

domains, which strengthen or weaken the process, were included as areas of influence, in addition to the operational domains, rather than simply as the target of the interpersonal elements that arise from the process. These could include contextual or descriptive factors such as political, economic, historical and socio-cultural circumstances. These factors are generally recognised as important but are often excluded because community empowerment programmes are considered to have little effect on them (Rifkin, 1990). This suggests that in future programmes should explicitly target these factors as areas of influence from the very beginning. Furthermore, that research should seek to identify approaches that can help to influence these factors where traditional approaches have failed to have an effect.

This thesis does however address one further critique that can be leveled at the domains models of community empowerment. Despite describing the process of community empowerment the previous models provided simply a list of the components of this mechanism with little systematic exposition of the principles of their operation. The theory developed in this thesis has provided a description of the mechanism that includes both the components and a nascent understanding of the principles of their operation. Researchers in the future would benefit from drawing on this theory to develop a new model for investigating the community mobilisation process, which explores not simply the operational domains but also the actions of the interventions and immediate, intermediate and long-term outcomes within each domain.

## **8.4 Implications for future policy and research**

### **8.4.1 Improving the MaiMwana women's group intervention**

The MaiMwana women's group intervention was successful at improving MCH and reducing mortality. The findings from this thesis suggest that this was, at least in part, achieved through the intervention empowering individuals, organisations and communities to take action on the structural and intermediary SDH. However, the findings also show that the intervention did not impact equally on all the SDH. Furthermore, that it did not manage to generate the interpersonal resources and relationships in all communities in which it was operating.

The socio-environmental mechanism developed in this thesis provides the opportunity to trace instances where the structural and intermediary determinants of health were not addressed back to the actions undertaken or not undertaken by the intervention (figure 8e - page 325). Doing this raises five key recommendations for improving the impact of the intervention on the social determinants of MCH health and thus on MCH and mortality.

First, the intervention should seek to further strengthen the knowledge of women's group members about MCH. In particular, it should provide more training to raise their awareness of the health problems affecting women and children, the root socio-environmental causes of these problems and the importance and benefits of focussing time and energy on identifying

and addressing these problems and causes. This should be undertaken in a participatory manner to ensure the intervention does not become a different type of community mobilisation intervention; namely one that seeks to educate rather than empower community members.

Second, the intervention should seek to better and more clearly explain what it is trying to achieve and how it will do this. In particular, it should conduct more sensitisation meetings, at all levels. Although this was done extensively during implementation more attention should be paid to better explaining the principles, aims and objectives of the intervention, its potential to bring benefits and the roles and responsibilities of the external agent and women's group members in its processes. Furthermore, through additional training and refined tools and materials the intervention should more clearly define technical terms such as neonate, priority and MCH problems.

Third, the intervention should seek to further strengthen the skills of women's group members to organise themselves and take control of the programme. In particular, the intervention should provide more training to build their skills in leadership, organisation, management and facilitation.

Fourthly, the intervention should seek to ensure it is accessible to all community members. In particular, through sensitisation meetings and recruitment activities, at all levels, it should provide greater opportunities for women who have never been pregnant, of all ages, and men to participate in meetings and discussions about MCH issues.

Finally, MaiMwana Project should engage in greater advocacy at all levels. In particular, it should work to develop stronger and more stable links with communities. Furthermore, it should work more extensively with potential partners and stakeholders to encourage them to work with women's group members and to advocate and challenge those with power over them.

#### **8.4.2 Improving other community mobilisation interventions**

Although the socio-environmental mechanism developed in this thesis is specific to the MaiMwana women's group intervention and the context in which it was implemented, it has implications for other community mobilisation interventions that also seek to empower communities to address the SDH. The findings of this thesis highlight the key organisation and mobilisation capacities of community members that these interventions should purposefully seek to build. They should seek to build the knowledge and skills, provide opportunities and change the attitudes of community members about the nine community empowerment domains. In doing this they have the greatest chance of triggering a mechanism that empowers communities to take control of the SDH.

### **8.4.3 Sustainability**

The findings show that the women's group intervention succeeded in building the capacities of women's group members to organise and mobilise themselves to take action. Logically, once built, these capacities can be considered to form a resource that communities can draw on to continue organising and mobilising themselves to take action to achieve shared goals in the future. Indeed, anecdotal evidence from the MIRA Makwanpur study in Nepal supports this assumption of sustainability showing that after an 18 month period without support from the external agent, approximately 75% of the groups were still meeting and taking action to address their MCH issues (Costello, 2012, personal communication).

However, the findings of this thesis also show that the MaiMwana women's group intervention failed to develop the necessary organisation and mobilisation capacities equally in all communities and that the external agent has an important ongoing role in supporting and building capacities in communities to take action. Drawing on this, MaiMwana Project developed a scale-up model for the women's group intervention seeking to maximise sustainability. The first step, which has already been undertaken, was to hand over key capacities and responsibilities for facilitation of the process to local volunteers. The second step, which has yet to be undertaken, is to hand over external agent capacities and responsibilities to the community and district level Ministry of Health representatives. The findings of this thesis support the first step but raise questions over the feasibility of the second since as communities become empowered the Ministry of Health systems often become the target of social and political action to improve MCH. In this context it may be more suitable to build the capacities and responsibilities of local CBOs and NGOs to take on the role of the external agent. Further investigation is needed to assess the effectiveness and sustainability of such an approach.

### **8.4.4 Potential future research**

Further research is required to extend and test the mechanism developed in this thesis. First, the mechanism has been presented in a simple linear manner despite an understanding that in reality it is dynamic and complex in nature. Future research to tease out the complexities of this mechanism in more depth could help to develop a more dynamic and realistic interpretation. In particular this could help to explore the interaction between the nine domains of community empowerment and how the organisation and mobilisation of women's group members loops back to unlock additional capacities on which they can draw on to further organise and mobilise themselves.

Second, the mechanism developed is not the only way in which MaiMwana women's groups are improving MCH and reducing mortality. Future research into the physiological and behavioural mechanisms through which the intervention also works, and how these interact

with each other and the socio-environmental mechanism explored in this thesis, could help to develop a complete understanding of how it improves MCH and reduces mortality.

Third, the MaiMwana women's group intervention was implemented within a specific context. This context: influences the capacities available for community members to organise and mobilise themselves, mediates how women's group members can organise and mobilise themselves, mediates the interpersonal resources and relationships generated through this organisation and mobilisation and underpins the structural and intermediary SDH. Future research to define this context and its impact on the capacities, organisation and mobilisation, interpersonal elements and social determinants could help to develop a better understanding of whether and how the intervention could be transferred to other settings.

Finally, the mechanism developed needs to be empirically tested. Future research could achieve this by measuring the capacities, organisation and mobilisation, interpersonal resources and relationships and SDH in communities with and without women's groups and exploring the associations between these. Measures of the impact of the intervention on capacities, organisation and interpersonal resources and relationships are also useful in their own right as they can reveal the wider effect of the intervention beyond mortality, morbidity and behaviour change.



**Table 8e: Lack of capacities built, organisation enabled and interpersonal elements generated by the MaiMwana women's group intervention**

Long-term outcomes		Intermediate outcomes	Intermediate outcomes	Immediate outcomes	Activities
The women's group members fail to gain access to collective resources and relationships that can help them to take action to improve MCH and reduce mortality	The process of women's group members failing to organise and mobilise themselves as fails to generate collective resources and relationships to help them to take action to improve MCH and reduce mortality	The women's group members fail to organise and mobilise themselves as fails to generate collective resources and relationships to help them to take action to improve MCH and reduce mortality	The women's group members fail to organise and mobilise themselves as fails to generate collective resources and relationships to help them to take action to improve MCH and reduce mortality	The women's group members do not have the capacities to improve MCH and reduce mortality	The actions undertaken by the women's group intervention fail to build the capacities of women's group members to organise and mobilise themselves to take action to improve MCH and reduce mortality
Lack of improvement of knowledge of:					
• MCH problems, contributing factors, solutions and strategies.		Community members fail to generate other with others in similar circumstances by participating in women's groups.	Community members fail to generate other with others in similar circumstances by participating in women's groups.		
Lack of improvement of skills in:		Community members fail to identify common concerns and solutions by assessing problems in women's groups.	Community members fail to identify common concerns and solutions by assessing problems in women's groups.		
• MCH problems, contributing factors, solutions and strategies.		Community members fail to identify common concerns and solutions by assessing problems in women's groups.	Community members fail to identify common concerns and solutions by assessing problems in women's groups.		
Lack of increased physical resources:		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• resources to implement strategies in practice.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• resources to address their concerns.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
Lack of development of psychological resources:		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• no sense of competence.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• dependence on external agent.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
Lack of increased trust between:		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• community members within the same community;		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• community members in different communities.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• community members and external organisations.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
Reduced participation in:		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• MCH activities.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• other MCH activities.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
Follows to engage in collective action:		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		
• problems in practice including those to address the root causes of MCH problems.		Community members fail to receive education and structure solutions by assessing problems in women's groups.	Community members fail to receive education and structure solutions by assessing problems in women's groups.		

This thesis aimed to surface the socio-environmental mechanism through which community mobilisation interventions improve health and reduce mortality. To achieve this the thesis explored the MaiMwana women's group intervention and revealed that **it improves MCH and reduces mortality by providing opportunities for, and building the knowledge, skills and attitudes of, women's group members to organise and mobilise themselves to take control of MCH and harness the benefits that arise from this process and use them to address the social determinants of MCH. In other words, it empowers women's group members to take individual, organisational and community action to address the social determinants of MCH.** While studies of other interventions support these findings and have illustrated components of this mechanism none have constructed it in its entirety from intervention inputs to outcomes that address the SDH.

## References

- AbouZahr, C., 2003. Global burden of maternal death and disability. *British Medical Bulletin*, 67(1), pp.1 -11.
- Ahmed, Y. et al., 1999. A study of maternal mortality at the University Teaching Hospital, Lusaka, Zambia: the emergence of tuberculosis as a major non-obstetric cause of maternal death. *The International Journal of Tuberculosis and Lung Disease*, 3(8), pp.675-680.
- Albee, G., 1981. Politics, power, prevention and social change. In *Prevention through political action and social change*. Hanover and London: University Press of New England.
- Alinsky, S.D., 1969. *Reveille for radicals*, New York: Vintage Books.
- Alinsky, S.D., 1971. *Rules for Radicals: A Practical Primer for Realistic Radicals*, New York: Vintage Books.
- Anderson, P.J.J. et al., 2006. Understanding Mechanisms in Organisational Research. *Journal of Management Inquiry*, 15(2), pp.102 -113.
- Bachrach, P. & Baratz, M.S., 1970. *Power and Poverty: Theory and Practice*, London, New York: Oxford University Press.
- Bandura, A, 1982. Self-efficacy in human agency. *American Psychologist*, 37, pp.122-147.
- Bandura, Albert, 1986. *Social foundations of thought and action: a social cognitive theory*, Englewood Cliffs, NJ: Prentice-Hall.
- Barrig, M., 1990. Women and development in Peru: old models, new actors. *Community Development Journal*, 25(4), pp.377-385.
- Basu, I. & Jana, S., 2004. HIV Prevention Among Sex Workers in India. *Journal of acquired immune deficiency syndromes*, 36(3), p.845.
- Batten, T.R., 1967. *The non-directive approach in group and community work*, London: Oxford University Press.
- Beck, C.T., 1993. Qualitative research: the evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research*, 15(2), pp.263-266.
- Bhaskar, R., 1997. *A Realist Theory of Science*, London: Routledge.

Bhutta, Z.A. et al., 2010. Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn, and child survival. *Lancet*, 375(9730), pp.2032-2044.

Black, D. a. . et al., 1990. *Inequalities in Health: The Black Report and The Health Divide*, London: Penguin Books.

Black, R.E. et al., 2010. Global, regional, and national causes of child mortality in 2008: a systematic analysis. *Lancet*, 375(9730), pp.1969-1987.

Blankenship, K.M., Burroway, R. & Reed, E., 2010. Factors associated with awareness and utilisation of a community mobilisation intervention for female sex workers in Andhra Pradesh, India. *Sexually Transmitted Infections*, 86 Suppl 1, pp. 169-75.

Blankenship, K.M. et al., 2008. Power, community mobilisation, and condom use practices among female sex workers in Andhra Pradesh, India. *AIDS (London, England)*, 22 Suppl 5, pp.S109-116.

Bookman, A. & Morgan, S., 1988. *Women Politics And Empowerment*, Philadelphia: Temple University Press.

Bopp, M. et al., 1999. *Evaluating community capacity for change*, Calgary: Four Worlds Development.

Boseley, S., 2006. Herceptin costs “put other patients at risk.” *Guardian Weekly*.

Brabin, B.J., Hakimi, M. & Pelletier, D., 2001. An analysis of anemia and pregnancy-related maternal mortality. *The Journal of Nutrition*, 131(2S-2), p.604S-615S.

Braithwaite, R.L. & Lythcott, N., 1989. Community empowerment as a strategy for health promotion for black and other minority populations. *The Journal of the American Medical Association*, 261(2), pp.282-283.

Bryce, J. et al., 2003. Reducing child mortality: can public health deliver? *Lancet*, 362(9378), pp.159-164.

Busza, J. & Schunter, B.T., 2001. From competition to community: participatory learning and action among young, debt-bonded Vietnamese sex workers in Cambodia. *Reproductive Health Matters*, 9(17), pp.72-81.

Campbell, C. & Cornish, F., 2010a. *How can community health programmes build enabling environments for transformative communication?: Experiences from India and South Africa*, London, UK: London School of Economics and Political Science.

Campbell, C. & Cornish, F., 2010b. Towards a “fourth generation” of approaches to HIV/AIDS management: creating contexts for effective community mobilisation. *AIDS Care*, 22 Suppl 2, pp.1569-1579.

Campbell, C. & Cornish, F., 2012. How can community health programmes build enabling environments for transformative communication? Experiences from India and South Africa. *AIDS and Behavior*, 16(4), pp.847-857.

Campbell, C., Nair, Y. & Maimane, S., 2007. Building contexts that support effective community responses to HIV/AIDS: a South African case study. *American Journal of Community Psychology*, 39(3-4), pp.347-363.

Campbell, M.K., Elbourne, D.R. & Altman, D.G., 2004. CONSORT statement: extension to cluster randomised trials. *BMJ*, 328(7441), pp.702-708.

Carpenter Rinaldi, D., 1995. Grounded theory research approach. In *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: J.B. Lippincott company.

Charmaz, C., 2000. Grounded Theory: Objectivist and Constructivist Methods. In *Handbook of Qualitative Research*. London: Sage.

Chavis, D. & Wandersman, A, 1990. Sense of community in the urban environment: A catalyst for participation and community development. *American Journal of Community Psychology*, 18, pp.55-82.

Le Coeur, S. et al., 2005. HIV and the magnitude of pregnancy-related mortality in Pointe Noire, Congo. *AIDS*, 19(1), pp.69-75.

Cohen, D., Vega, R.D. la & Watson, G., 2001. *Advocacy for social justice: a global action and reflection guide*, Bloomfield, CT: Kumarian Press.

Commission for the Social Determinants of Health, 2008. *Closing the gap in a generation: health equity through action on the SDH. Final report of the commission on Social Determinants of Health*, Geneva: World Health Organisation.

- Cornish, F. & Ghosh, R., 2007. The necessary contradictions of “community-led” health promotion: a case study of HIV prevention in an Indian red light district. *Social Science & Medicine*, 64(2), pp.496-507.
- Costantino-David, K., 1995. Community organizing in the Philippines: the experience of development NGOs. In *A reader in participation and development*. London: Zed Books.
- Craver, C.F., 2001. Role Functions, Mechanisms, and Hierarchy. *Philosophy of Science*, 68, p. 53.
- Creswell, J.W., 2009. *Research design: qualitative, quantitative, and mixed methods approaches*, Newbury Park, CA: Sage Publications Ltd.
- Crowfoot, J., 1981. Accommodating growth in democratically managed organisations. *Moving food: A trade Journal of the Cooperating Food Distribution System*, pp.40-43.
- Cummins, R., 1975. Functional analysis. *The Journal of Philosophy*, 72(20), pp.741-765.
- Darmstadt, G.L. et al., 2005. Evidence-based, cost-effective interventions: how many newborn babies can we save? *Lancet*, 365(9463), pp.977-988.
- Denzin, N. & Lincoln, Y. eds., 2000. *Handbook of Qualitative Research* 2nd ed., London: Sage Publications Ltd.
- Diderichsen, F., Evans, T. & Whitehead, M., 2001. The social basis of health disparities. In *Challenging inequalities in Health*. New York: Oxford University Press.
- Donaldson, S.I. & Lipsey, M.W., 2006. Roles for theory in contemporary evaluation practice: Developing practice knowledge. In *The handbook of evaluation: Policies, programs, and practices*. London: Sage.
- Donaldson, S.I., 2007. *Program Theory-Driven Evaluation Science: Strategies and Applications*, London: Routledge.
- Dong, W., Fung, K. & Chan, K.C., 2010. Community mobilisation and empowerment for combating a pandemic. *Journal of Epidemiology and Community Health*, 64(2), pp.182-183.
- Eisen, A., 1994. Survey of neighbourhood-based, comprehensive community empowerment initiatives. *Health Education Quarterly*, 21(2), pp.235-252.

Eklund, L., 1999. From citizen participation towards community empowerment. PhD. Faculty of Medicine of the University of Tampere.

Ekwempu, C.C. et al., 1990. Structural adjustment and health in Africa. *Lancet*, 336(8706), pp. 56-57.

Eng, E. & Parker, E., 1994. Measuring Community Competence in the Mississippi Delta: The Interface between Program Evaluation and Empowerment. *Health Education & Behavior*, 21(2), pp.199 -220.

Evans, C. & Lambert, H., 2008a. Implementing community interventions for HIV prevention: insights from project ethnography. *Social Science & Medicine*, 66(2), pp.467-478.

Evans, C. & Lambert, H., 2008b. Implementing community interventions for HIV prevention: insights from project ethnography. *Social Science & Medicine*, 66(2), pp.467-478.

Fawcett, S.B. et al., 1995. Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology*, 23(5), pp. 677-697.

Fawcus, S.R., van Coeverden de Groot, H.A. & Isaacs, S., 2005. A 50-year audit of maternal mortality in the Peninsula Maternal and Neonatal Service, Cape Town (1953-2002). *International Journal of Obstetrics and Gynaecology*, 112(9), pp.1257-1263.

Fernandez, A. & Osrin, David, 2006. The City Initiative for Newborn Health. *PLoS Medicine*, 3(9), p.e339.

Filippi, V. et al., 2006. Maternal health in poor countries: the broader context and a call for action. *Lancet*, 368(9546), pp.1535-1541.

Filler, S.J. et al., 2006. Randomized trial of 2-dose versus monthly sulfadoxine-pyrimethamine intermittent preventive treatment for malaria in HIV-positive and HIV-negative pregnant women in Malawi. *The Journal of Infectious Diseases*, 194(3), pp.286-293.

Florin, P. & Wandersman, A, 1990. An introduction to citizen participation, voluntary organisations, and community development: Insights for empowerment through research. *American Journal of Community Psychology*, 18, pp.41-54.

Fortney, J.A., 1985. Maternal mortality in Indonesia and Egypt.

Freire, P., 1973. *Education For Critical Consciousness*, New York: Continuum International Publishing Group.

Freire, P., 1970. *Pedagogy of the Oppressed*, New York: Continuum International Publishing Group.

Freire, P., 1996. *Pedagogy of the Oppressed (New Revised Edition)*, New York: Continuum International Publishing Group.

Gangopadhyay, D.N. et al., 2005. Evaluation of sexually transmitted diseases/human immunodeficiency virus intervention programs for sex workers in Calcutta, India. *Sexually Transmitted Diseases*, 32(11), pp.680-684.

Gaventa, J., 1982. *Power and Powerlessness: Quiescence and Rebellion in an Appalachian Valley*, Chicago: University of Illinois Press.

Genberg, B.L. et al., 2008. HIV risk behaviors in sub-Saharan Africa and Northern Thailand: baseline behavioral data from Project Accept. *Journal of Acquired Immune Deficiency Syndromes*, 49(3), pp.309-319.

Gerschick, T.J., Israel, B.A. & Checkoway, B., 1990. *Means of Empowerment in Individuals, Organisations, and Communities: Report on a Retrieval Conference*, PCMA Working Paper #23.

Ghose, T. et al., 2008. Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: the boundaries, consciousness, negotiation framework. *Social Science & Medicine*, 67(2), pp.311-320.

Gibbon, M., 1999. *Meetings with meaning: health dynamics in rural Nepal*. PhD. London: South Bank University.

Glaser, B.G., 1978. *Theoretical sensitivity: Advances in the methodology of grounded theory*, Mill Valley, California: Sociology Press.

Glaser, B.G. & Strauss, A.L., 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*, Chicago: Aldine.



Goede, R. & de Villiers, C., 2003. The applicability of grounded theory as research methodology in studies on the use of methodologies in IS practices. In *Proceedings of the 2003 annual research conference of the South African institute of computer scientists and information technologists on Enablement through technology*. SAICSIT '03. Republic of South Africa: South African Institute for Computer Scientists and Information Technologists, pp. 208–217.

Goodman, R.M., Speers, M.A., et al., 1998. Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement. *Health Education & Behavior*, 25(3), pp.258 -278.

Gottlieb, N. H. & McLeroy, K.R., 1994. Social Health. In *Health Promotion in the Workplace*. Albany, NY: Delmar, pp. 459-493.

Graham, H. & Kelly, M.P., 2004. *Health Inequalities: Concepts, Frameworks and Policy*, London: National Health Service, Health Development Agency.

Graham, W J & Newell, M.L., 1999. Seizing the opportunity: collaborative initiatives to reduce HIV and maternal mortality. *Lancet*, 353(9155), pp.836-839.

Gruber, J. & Trickett, E.J., 1987. Can we empower others: The paradox of empowerment in the governing of an alternative public school. *American Journal of Community Psychology*, 15(3), pp.353-372.

Gupta, R, Gupta, V.P. & Ahluwalia, N.S., 1994. Educational status, coronary heart disease, and coronary risk factor prevalence in a rural population of India. *BMJ*, 309(6965), pp.1332-1336.

Gupta, S.D. et al., 2010. Maternal mortality ratio and predictors of maternal deaths in selected desert districts in Rajasthan a community-based survey and case control study. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, 20(1), pp.80-85.

Gutierrez, L.M., 1990. Working with women of color: an empowerment perspective. *Social Work*, 35, pp.149-153.

Gwatkin, D.R., Wagstaff, A. & Yazbeck, A., 2005. *Reaching the Poor With Health, Nutrition, and Population Services: What Works, What Doesn't, and Why*, Washington, DC: World Bank Publications.

Hart, E. & Bond, M., 1995. *Action research for health and social care: a guide to practice*, Buckingham: Open University Press.

Hauritz, M. & Australian Institute of Criminology, 1998. *Reducing Violence in Licensed Venues: Community Safety Action Projects*, Canberra: Australian Institute of Criminology.

Hawe, P. et al., 2000. *Indicators to help with capacity building in health promotion*, Sydney: Australian Centre for Health Promotion / NSW Health.

Heath, H. & Cowley, S., 2004. Developing a grounded theory approach: a comparison of Glaser and Strauss. *International Journal of Nursing Studies*, 41(2), pp.141-150.

Heath, M. & Dunham, A., 1963. *Trends in community organisation*, Chicago: School of Social Service Administration, University of Chicago.

Hickson, F.C.I., 1999. *Tools for map making*, London: Sigma Research.

Hildebrandt, E., 1996. Building community participation in health care: a model and example from South Africa. *Image--the Journal of Nursing Scholarship*, 28(2), pp.155-159.

Hoffman, K. & Dupont, J.-M., 1992. *Community Health Centres and Community Development*, Toronto: Health and Welfare Canada.

Hogan, M.C. et al., 2010. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet*, 375(9726), pp. 1609-1623.

Holder, H.D., Gruenewald, P.J., Ponicki, W.R., Treno, A.J., Grube, J.W., Saltz, R.F., Voas, R.B., Reynolds, R., Davis, J., Sanchez, L., Gaumont, G. & Roeper, P., 2000a. Effect of community-based interventions on high-risk drinking and alcohol-related injuries. *The Journal of the American Medical Association*, 284(18), pp.2341-2347.

Holder, H.D., Gruenewald, P.J., Ponicki, W.R., Treno, A.J., Grube, J.W., Saltz, R.F., Voas, R.B.,

Reynolds, R., Davis, J., Sanchez, L., Gaumont, G. & Roeper, P., 2000b. Effect of community-based interventions on high-risk drinking and alcohol-related injuries. *The Journal of the American Medical Association*, 284(18), pp.2341-2347.

Homel, R. et al., 1997. Preventing alcohol-related crime through community action: the Surfers Paradise safety action project, Policing for Prevention: Reducing Crime, Public Intoxication and Injury. In *Policing for Prevention: Reducing Crime, Public Intoxication, and Injury*. Monsey, NY: Criminal Justice Press,.

Hong, R., 2008. Association of maternal HIV infection with increase of infant mortality in Malawi. *Journal of Paediatrics and Child Health*, 44(5), pp.291-296.

Hounton, S., Byass, P. & Brahim, B., 2009. Towards reduction of maternal and perinatal mortality in rural Burkina Faso: communities are not empty vessels. *Global Health Action*, 2.

Hounton, S., Chapman, G., et al., 2008. Accessibility and utilisation of delivery care within a Skilled Care Initiative in rural Burkina Faso. *Tropical Medicine & International Health: TM & IH*, 13 Suppl 1, pp.44-52.

Hounton, S., Menten, J., et al., 2008. Effects of a Skilled Care Initiative on pregnancy-related mortality in rural Burkina Faso. *Tropical Medicine & International Health: TM & IH*, 13 Suppl 1, pp.53-60.

Howard-Grabman, L. & Snetro, G., 2003. *How to Mobilise Communities for Health and Social Change: A Field Guide*, USA: Health Communication Partnership.

Ilika, A.L. & Ilika, U.R., 2005. Eliminating gender-based violence: learning from the widowhood practices elimination initiative of a women organisation in Ozubulu, Anambra State of Nigeria. *African Journal of Reproductive Health*, 9(2), pp.65-75.

Irwin, A. et al., 2006. The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities. *PLoS Med*, 3(6), p.e106.

Israel, B A, Checkoway, B, et al., 1994. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organisational, and community control. *Health Education Quarterly*, 21(2), pp.149-170.

Israel, B.A., Checkoway, B., et al., 1994. Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organisational, and Community Control. *Health Education & Behavior*, 21(2), pp.149 -170.

Jackson, T., Mitchell, S. & Wright, M., 1989. The community development continuum. *Community Health Studies*, 13(1), pp.66-73.

Jana, S., Basu, I., Rotheram-Borus, M.J. & Newman, P.A., 2004a. The Sonagachi Project: a sustainable community intervention program. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, 16(5), pp.405-414.

Jana, S., Basu, I., Rotheram-Borus, M.J. & Newman, P.A., 2004b. The Sonagachi Project: a sustainable community intervention program. *AIDS Education and Prevention: Official Publication of the International Society for AIDS Education*, 16(5), pp.405-414.

Jones, L. et al., 2011. Reducing harm in drinking environments: a systematic review of effective approaches. *Health & Place*, 17(2), pp.508-518.

Jones, L.J. & Sidell, M., 1997. *The Challenge of Promoting Health: Exploration and Action*, Basingstoke: Macmillan.

Kahn, S., 1982. *Organizing: a guide for grassroots leaders*, New York: McGraw-Hill.

Kasongo Project Team, 1984. Antenatal screening for fetopelvic dystocias. A cost-effectiveness approach to the choice of simple indicators for use by auxiliary personnel. The Kasongo Project Team. *The Journal of Tropical Medicine and Hygiene*, 87(4), pp.173-183.

Katz, R., 1983. Empowerment and synergy: expanding the community's healing resources. *Prevention in Human Services*, 3(2-3), pp.201-230.

Kawachi, I. et al., 1997. Social capital, income inequality, and mortality. *American Journal of Public Health*, 87(9), pp.1491-1498.

Khumalo-Sakutukwa, G. et al., 2008. Project Accept (HPTN 043): a community-based intervention to reduce HIV incidence in populations at risk for HIV in sub-Saharan Africa and Thailand. *Journal of Acquired Immune Deficiency Syndromes (1999)*, 49(4), pp.422-431.

Kieffer, C., 1981. *The emergence of empowerment: The development of participatory competence among individuals in citizen organisations*. PhD. Ann Arbor: University of Michigan.

Kieffer, C.H., 1984. Citizen empowerment: a developmental perspective. *Prevention in Human Services*, 3(2-3), pp.9-36.

Labonte, R., 1989. Community empowerment: reflections on the Australian situation. *Community Health Studies*, 13(3), pp.347-349.

Labonte, R., 1990. Empowerment: Notes on professional and community dimensions. *Canadian Review of Social Policy*, 26, pp.4-75.

Labonte, R, 1992. Heart health inequalities in Canada: modules, theory and planning. *Health Promotion International*, 7(2), pp.119 -128.

Labonte, R.N., 1993. *Health Promotion and Empowerment: Practice Frameworks*, Toronto: Centre for Health Promotion, University of Toronto.

Labonte, R, 1994. Health promotion and empowerment: reflections on professional practice. *Health Education Quarterly*, 21(2), pp.253-268.

Labonte, R, 1996. *Community Development in the Public Health Sector: The Possibilities of an Empowering Relationship Between the State and Civil Society*. PhD. Toronto: York University.

Labonte, R, 1997. Community, Community Development, and the Forming of Authentic Partnerships: Some Critical Reflections. In *Community organizing and capacity building for health*. New Brunswick: Rutgers University Press.

Labonte, R, 1998. *A community development approach to health promotion: a background paper on practice tensions, strategic models and accountability requirements for health authority work on the broad determinants of health*, Edinburgh: Health Education Board for Scotland.

Labonte, R. & Laverack, G., 2001. Capacity building in health promotion, Part 1: for whom? And for what purpose. *Critical Public Health*, 11(2).

Labonte, R.N., Reid, E. & Foundation, V.H.P., 1997. *Power, Participation and Partnerships for Health Promotion*, Carlton, Victoria: Vichealth.

Labonte, R & Robertson, A., 1996. Delivering the goods, showing our stuff: the case for a constructivist paradigm for health promotion research and practice. *Health Education Quarterly*, 23(4), pp.431-447.

Laverack, G., 1999. *Addressing the contradiction between discourse and practice in health promotion*. PhD. Deakin University.

Laverack, G., 2001. An identification and interpretation of the organisational aspects of community empowerment. *Community Development Journal*, 36(2), pp.134-145.

Laverack, G., 2003. Building capable communities: experiences in a rural Fijian context. *Health Promotion International*, 18(2), pp.99-106.

Laverack, G., 2004a. *Health promotion practice: power and empowerment*, London: Sage Publications Ltd.

Laverack, G., 2004b. *Health Promotion Practice: Power and Empowerment*, Thousand Oaks, California: Sage Publications Ltd.

Laverack, G., 2005a. Evaluating community capacity: visual representation and interpretation. *Community development journal*.

Laverack, G., 2005b. *Public Health: Power and Professional Practice* 1st ed., Basingstoke, UK: Palgrave Macmillan.

Laverack, G., 2005c. Using a “domains” approach to build community empowerment. *Community Development Journal*.

Laverack, G., 2006. Improving health outcomes through community empowerment: a review of the literature. *Journal of Health, Population and Nutrition*, 24(1), pp.113-120.

Laverack, G., 2007a. Building the capacity of Fijian communities to improve health outcomes. *Pac Health Dialog*, 14(2), pp.95-100.

Laverack, G., 2007b. *Health promotion practice: building empowered communities*, London: McGraw-Hill International.

Laverack, Glenn, 2009. *Public Health: Power, Empowerment and Professional Practice*, Basingstoke: Palgrave Macmillan.

Laverack, G & Labonte, R, 2000. A planning framework for community empowerment goals within health promotion. *Health Policy and Planning*, 15(3), pp.255-262.

Laverack, G. & Thangphet, S., 2009. Building community capacity for locally managed ecotourism in Northern Thailand. *Community Development Journal*, 44(2), pp.172 -185.

Laverack, G. & Wallerstein, N., 2001. Measuring community empowerment: a fresh look at organisational domains. *Health Promotion International*, 36(2), pp.179-185.

Laverack, G. & Whipple, A., 2010. The sirens’ song of empowerment: a case study of health promotion and the New Zealand Prostitutes Collective. *Global Health Promotion*, 17(1), pp. 33-8.

Lawn, J.E., Cousens, S. & Zupan, J., 2005. 4 million neonatal deaths: When? Where? Why? *The Lancet*, 365(9462), pp.891-900.

Lewycka, S, et al. 2010. A cluster randomised controlled trial of the community effectiveness of two interventions in rural Malawi to improve health care and to reduce maternal, newborn and infant mortality. *Trials*, 11, p.88.

Lewycka, S., 2011. *Reducing maternal and neonatal deaths in rural Malawi: evaluating the impact of a community-based women's group intervention*. PhD. London: University College London.

Lewycka, S et al., Submitted. Effect of women's groups and volunteer peer counsellors on mortality, morbidity and health behaviours among mothers and children in rural Malawi: the MaiMwana factorial cluster randomised controlled trial. *Lancet*.

Lipovsek, V. et al., 2010. Increases in self-reported consistent condom use among male clients of female sex workers following exposure to an integrated behaviour change programme in four states in southern India. *Sexually Transmitted Infections*, 86 Suppl 1, pp.25-32.

Locke, K., 1996. Rewriting the discovery of grounded theory after 25 years. *Journal of Management Inquiry*, 5(3), pp.239-245.

Longley, M., 2001. Partners in Planning. Information, Participation and Empowerment. *Health Promotion International*, 17(3), pp.285 -286.

Luttrell, C., Quiroz, S. & Scrutton, C. Empowerment: An overview. Available at: [www.poverty-wellbeing.net](http://www.poverty-wellbeing.net) [Accessed April 25, 2012].

MaCallan, L. & Narayan, V., 1994. Keeping the heart beat in Grampian - a case study in community participation and ownership. *Health Promotion International*, 9(1), pp.13-19.

Machamer, P., Darden, L. & Craver, C.F., 2000. Thinking about mechanisms. *Philosophy of Science*, 67(1), pp.1-25.

Mahy, M., 2003. *Childhood mortality in the developing world: a review of evidence from the demographic and health surveys*, Calverton, Maryland: MEASURE DHS+, ORC Macro.

Maier, S.F. & Seligman, M.E., 1976. Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General*, 105, pp.3-46.

Maine, D., 1987. Prevention of maternal deaths in developing countries: Program options and practical considerations.

Manandhar, D.S. et al., 2004. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. *Lancet*, 364(9438), pp.970-9.

Manandhar, S.R. et al., 2010. Causes of stillbirths and neonatal deaths in Dhanusha district, Nepal: a verbal autopsy study. *Kathmandu University Medical Journal*, 8(29), pp.62-72.

Mark, M.M., Henry, G.T. & Julnes, G., 2000. *Evaluation: an integrated framework for understanding, guiding, and improving policies and programs*, San Francisco: Jossey-Bass.

Marmot, M. & Wilkinson, R., 1999. *Social Determinants of Health*. 2nd ed., Oxford: Oxford University Press.

Marsden, D., Oakley, P. & Pratt, B., 1994. *Measuring the Process: Guidelines for Evaluating Social Development*, Oxford: Intrac.

May, P., Miller, J. & Wallerstein, N., 1993. Motivation and community prevention of substance abuse. *Experimental and Clinical Pharmacology*, 1(1-4), pp.68-79.

Mayntz, R., 2004. Mechanisms in the analysis of social macro-phenomena. *Philosophy of the Social Sciences*, 34(2), pp.237-259.

McCall, M., 1988. The implications of Eastern African rural social structure for local level development: the case for participatory development based in indigenous knowledge systems. *Regional Development Dialogue*, 9(2), pp.41-69.

McCarthy, J. & Maine, D., 1992. A framework for analyzing the determinants of maternal mortality. *Studies in Family Planning*, 23(1), pp.23-33.

McCoy, D. et al., 2005. *Going from bad to worse: Malawi's maternal mortality: the problem summarised with recommendations for national and international stakeholders*, Durban: Health Systems Trust and Global Equity Gauge Alliance.

McGinnis, J.M., Williams-Russo, P. & Knickman, J.R., 2002. The case for more active policy attention to health promotion. *Health Affairs (Project Hope)*, 21(2), pp.78-93.

McLeroy, K.R. et al., 2003. Community-based interventions. *American Journal of Public Health*, 93(4), pp.529-533.



Midford, R. et al., 2005. The legacy of a community mobilisation project to reduce alcohol related harm. *Drug and Alcohol Review*, 24(1), pp.3-11.

Minkler, M., 1994. Ten commitments for community health education. *Health Education Research*, 9(4), pp.527-534.

Minkler, M. & Cox, K., 1980. Creating critical consciousness in health: applications of Freire's philosophy and methods to the health care setting. *International Journal of Health Services: Planning, Administration, Evaluation*, 10(2), pp.311-322.

Moghaddam, A., 2006. Coding issues in grounded theory. *Issues in Educational Research*, 16(1), pp.52-66.

More, N. et al., 2008. Cluster-randomised controlled trial of community mobilisation in Mumbai slums to improve care during pregnancy, delivery, postpartum and for the newborn. *Trials*, 9, p.7.

Morris, R., Binstock, R.H. & Rein, M., 1966. *Feasible Planning for Social Change*, New York, NY: Columbia University Press.

Morrison, J. et al., 2005. Women's health groups to improve perinatal care in rural Nepal. *BMC Pregnancy and Childbirth*, 5(1), p.6.

Morse, J.M. & Richards, L., 2002. *Read Me First for a User's Guide to Qualitative Methods*, Thousand Oaks, London, New Delhi: Sage Publications Ltd.

Mosley, W.H. & Chen, L.C., 2003. An analytical framework for the study of child survival in developing countries. 1984. *Bulletin of the World Health Organisation*, 81(2), pp.140-145.

Murray, C.J.L. et al., 2007. Can we achieve Millennium Development Goal 4? New analysis of country trends and forecasts of under-5 mortality to 2015. *Lancet*, 370(9592), pp.1040-1054.

NACO, 2006. *National AIDS Control Programme Phase III (2007-2012): Strategy and Implementation Plan*, New Dehli: Ministry of Health and Family Welfare; Government of India.

National Statistics Office (Malawi), 2008. *2008 Population and Housing Census*, Zomba, Malawi: National Statistics Office (Malawi).

National Statistics Office (Malawi) & ICF Macro, 2008. *Malawi Demographic and Health Survey 2004*, Calverton, Maryland: ICF Macro.

National Statistics Office (Malawi) & ICF Macro, 2010. *Malawi Demographic and Health Survey 2008*, Calverton, Maryland: ICF Macro.

Newlands, D. et al., 2008. Assessing the costs and cost-effectiveness of a skilled care initiative in rural Burkina Faso. *Tropical Medicine & International Health*, 13 Suppl 1, pp.61-67.

Ngondi, J. et al., 2009. Evaluation of three years of the SAFE strategy (Surgery, Antibiotics, Facial cleanliness and Environmental improvement) for trachoma control in five districts of Ethiopia hyperendemic for trachoma. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 103(10), pp.1001-1010.

Ngondi, J. et al., 2010. Effect of a community intervention with pit latrines in five districts of Amhara, Ethiopia. *Tropical Medicine and International Health*, 15(5), pp.592-9.

Nutbeam, D., 1998. Evaluating Health Promotion—Progress, Problems and solutions. *Health Promotion International*, 13(1), pp.27 -44.

Nyswander, D., 1956. Education for health: some principles and their application. *Health Education Monographs*, 14, pp.65-70.

O’Gorman, F., 1995. Brazilian community development: changes and challenges. In *Community empowerment: A reader in participation and development*. London: Zed Books.

O’Loughlin, J., 1997. Safe motherhood: impossible dream or achievable reality? *The Medical Journal of Australia*, 167(11-12), pp.622-625.

O’Loughlin, R. et al., 2006. Follow-up of a low cost latrine promotion programme in one district of Amhara, Ethiopia: characteristics of early adopters and non-adopters. *Tropical Medicine and International Health: TM & IH*, 11(9), pp.1406-1415.

Omran, A.R. & Standley, C.C. eds., 1976. *Family formation patterns and health: an international collaborative study in India, Iran, Lebanon, Philippines and Turkey*, Geneva: WHO.

Omu, A.E., 1981. Traditional midwives in Nigeria. *Lancet*, 1(8220 Pt 1), pp.620-621.

Ontario Health Promotion Resource System. Health Promotion Online Course. Available at: [www.ohprs.ca/hp101/main.htm](http://www.ohprs.ca/hp101/main.htm). [Accessed April 25, 2012].

Pajunen, K., 2005. Mechanisms in the explanation of organisational processes.

Pawson, R. & Tilley, N., 1997. *Realistic evaluation*, London: Sage Publications Ltd.

Pelletier, D. & Jonsson, V., 1994. The use of information in the Iringa Nutrition Programme. *Food Policy*, 19(3), pp.301-313.

Piwowar-Manning, E. et al., 2011. HIV surveillance in a large, community-based study: results from the pilot study of Project Accept (HIV Prevention Trials Network 043). *BMC Infectious Diseases*, 11, p.251.

Plough, A. & Olafson, F., 1994. Implementing the Boston Healthy Start Initiative: a case study of community empowerment and public health. *Health Education Quarterly*, 21(2), pp. 221-234.

Popay, J., 2000. Social capital: the role of narrative and historical research. *Journal of Epidemiology and Community Health*, 54(6), p.401.

Purdey, A.F. et al., 1994. Participatory health development in rural Nepal: clarifying the process of community empowerment. *Health Education Quarterly*, 21(3), pp.329-343.

Putnam, R., 2001. Foreword. In *Social capital and poor communities*. New York: Russell Sage Foundation.

Putnam, R.D., 2000. *Bowling alone: the collapse and revival of American community*, New York: Simon & Schuster.

Putnam, R.D., Leonardi, R. & Nanetti, R.Y., 1993. *Making Democracy Work: Civic Traditions in Modern Italy*, Princeton: Princeton University Press.

Quick, R., 2003. Changing community behaviour: experience from three African countries. *International Journal of Environmental Health Research*, 13 Suppl 1, pp.S115-121.

Rappaport, J., 1985. The Power of empowerment language. *Social Policy*, 16(2), pp.15-21.

Rappaport, J., Swift, C & Hess, R., 1984. *Studies in Empowerment: Steps Toward Understanding and Action*, London: Routledge.

Rath, S. et al., 2010. Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation. *BMC Int Health Hum Rights*, 10, p.25.

Rifkin, S.B. & Kangere, M., 2001. What is participation? In *CBR: A participatory strategy in Africa*. pp. 37-49.

Rifkin, S.B., 1990. *Community participation in mother and child health/family planning programmes: an analysis based on case study materials*, Geneva, Switzerland: World Health Organisation.

Rifkin, S.B., Muller, F. & Bichmann, W., 1988. Primary health care: on measuring participation. *Social Science & Medicine*, 26(9), pp.931-940.

Rissel, C., 1994. Empowerment: the holy grail of health promotion? *Health promotion international*, 9(1).

Roach, J.O., 2001. Injuries kill over 20000 children a year in developed countries. *BMJ*, 322(7282), p.317.

Roberts, G., 1997. The Kadavu health promotion model. *Health Promotion International*, 12(4), pp.283-290.

Roberts, H., 1997. Socioeconomic determinants of health: Children, inequalities, and health. *BMJ*, 314(7087), p.1122.

Rocha, C. et al., 2011. The Innovative Socio-economic Interventions Against Tuberculosis (ISIAT) project: an operational assessment. *The International Journal of Tuberculosis and Lung Disease: The Official Journal of the International Union Against Tuberculosis and Lung Disease*, 15 Suppl 2, pp.S50-57.

Ronsmans, C., Graham, Wendy J & group, L.M.S.S. steering, 2006. Maternal mortality: who, when, where, and why. *Lancet*, 368(9542), pp.1189-200.

Rooks, J.P. et al., 1989. Outcomes of care in birth centers. The National Birth Center Study. *The New England Journal of Medicine*, 321(26), pp.1804-1811.

Rosato, M et al., 2009. Women's groups' perceptions of neonatal and infant health problems in rural Malawi. *Malawi Medical Journal*, 21(4), pp.168-173.

Rosato, M. et al., 2008. Community participation: lessons for maternal, newborn, and child health. *Lancet*, 372(9642), pp.962-971.

Rosato, M. et al., 2006. Women's groups' perceptions of maternal health issues in rural Malawi. *Lancet*, 368(9542), pp.1180-1188.

Rosato, M. et al., 2010. MaiMwana women's groups: a community mobilisation intervention to improve mother and child health and reduce mortality in rural Malawi. *Malawi Medical Journal*, 22(4), pp.112-119.

Rossi, P.H., Lipsey, Mark W. & Freeman, H.E., 2004. *Evaluation: a systematic approach*, London: Sage Publications Ltd.

Rothman, J., 1968. Three models of community organisation practice. In *Social work practice*. New York: Columbia University Press.

Rothman, J & Tropman, J., 1987. Models of community organisation and macro practice perspectives: Their mixing and phasing. In *Strategies of community organisation*. Itasca, IL: F.E. Peacock Publishers.

Rothman, J & Tropman, J., 1970. Three models of community organisation practice, their mixing and phasing. In *Strategies of community organisation*. Itasca, IL: F.E. Peacock.

Rothman, J., 1995. *Strategies of community intervention: Macro practice*, Itasca, IL: F.E. Peacock Publishers.

Rotter, J.B., On the evaluation of methods of intervening in other people's lives. *Clinical Psychologist*, 24, p.1.

von Rueden, U. et al., 2006. Socioeconomic determinants of health related quality of life in childhood and adolescence: results from a European study. *Journal of Epidemiology and Community Health*, 60(2), pp.130-135.

Ryan, W., 1976. *Blaming the victim*, New York: Vintage Books.

Samik-Ibrahim, R.M., 2000. Grounded Theory Methodology as the Research Strategy for a Developing Country. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 1(1).

Sayer, R.A., 2000. *Realism and social science*, London: Sage Publications Ltd.

Schell, C.O. et al., 2007. Socioeconomic determinants of infant mortality: a worldwide study of 152 low-, middle-, and high-income countries. *Scandinavian Journal of Public Health*, 35(3), pp.288-297.

Schulz, A.J. et al., 1995. Empowerment as a multi-level construct: perceived control at the individual, organisational and community levels. *Health Education Research*, 10(3), pp.309-327.

Schulz, A. & Israel, B., 1991. Empowerment and Empowering Processes: A Theory Development Seminar Series. PCMA Working Paper #27.

Scriven, M., 1994. The fine line between evaluation and explanation. *Evaluation Practice*, 15(1), pp.75-77.

Seedat, M., Lazarus, S. & Duncan, N., 2001. *Community psychology: theory, method, and practice: South African and other perspectives*, Cape Town: Oxford University Press Southern Africa.

Seeman, M., 1959. On the meaning of alienation. *American Sociological Review*, 24, pp. 738-791.

Self-help resource centre of greater Toronto. Self-help. Available at: [www.selfhelp.on.ca/](http://www.selfhelp.on.ca/) [Accessed April 25, 2012].

Sewankambo, N.K. et al., 2000. Mortality associated with HIV infection in rural Rakai District, Uganda. *AIDS*, 14(15), pp.2391-2400.

Shah, I.H. & Say, L., 2007. Maternal mortality and maternity care from 1990 to 2005: uneven but important gains. *Reproductive Health Matters*, 15(30), pp.17-27.

Shrestha, B.P. et al., 2011. Community interventions to reduce child mortality in Dhanusha, Nepal: study protocol for a cluster randomized controlled trial. *Trials*, 12, p.136.

Shrimpton, R., 1995. Community participation in food and nutrition programmes: an analysis of recent governmental experiences. In *Child growth and nutrition in developing countries: Priorities for action*. Ithaca, NY: Cornell University Press.

Shulman, R.J. & Phillips, S., 2003. Parenteral nutrition in infants and children. *Journal of Pediatric Gastroenterology and Nutrition*, 36(5), pp.587-607.

Simons-Morton, B.G., Greene, W.H. & Gottlieb, Nell H., 1995. *Introduction to health education and health promotion*, Prospect Heights, IL: Waveland Press.

Solar, O. & Irwin, A., 2006. Social determinants, political contexts and civil society action: a historical perspective on the Commission on Social Determinants of Health. *Health Promotion Journal of Australia*, 17(3), pp.180-185.

Solar, O. & Irwin, A., 2007. *A Conceptual Framework for Action on the Social Determinants of Health*, Geneva: WHO.

Solomon, B.B., 1976. *Black Empowerment: Social Work in Oppressed Communities*, New York: Columbia University Press.

Starhawk, M.S., 1990. *Truth or dare: encounters with power, authority and mystery*, New York: HarperCollins.

Steckler, A.B. et al., 1993. Community health development: an overview of the works of Guy W. Steuart. *Health Education Quarterly*, Suppl 1, pp.S3-20.

Steketee, R W et al., 1996. Impairment of a pregnant woman's acquired ability to limit *Plasmodium falciparum* by infection with human immunodeficiency virus type-1. *The American Journal of Tropical Medicine and Hygiene*, 55(1 Suppl), pp.42-49.

Stern, P.N., 1994. Eroding grounded theory. In *Critical Issues in Qualitative Research Methods*. Newbury Park, California: Sage.

Steuart, G., 1985. Social and Behavioural Health Strategies. In *Aging and Public Health*. New York, NY: Springer.

Stevenson, H.M. & Burke, M., 1992. Bureaucratic logic in new social movement clothing: the limits of health promotion research. *Canadian Journal of Public Health. Revue Canadienne De Santé Publique*, 83 Suppl 1, pp.S47-53.

Stewart, A., 2001. *Theories of Power and Domination: The Politics of Empowerment in Late Modernity*, Thousand Oaks, California: Sage Publications Ltd.

Strauss, A.L., 1987. *Qualitative Analysis for Social Scientists*, Cambridge: Cambridge University Press.

Strauss, A.L. & Corbin, J.M., 1990. *Basics of qualitative research: grounded theory procedures and techniques*, London: Sage Publications Ltd.

Strauss, A.L. & Corbin, J.M., 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, London: Sage Publications Ltd.

Stronks, K., 2002. Generating evidence on interventions to reduce inequalities in health: the Dutch case. *Scandinavian Journal of Public Health. Supplement*, 59, pp.20-25.

Suddaby, R., 2006. What grounded theory is not. *Academy of Management Journal*, 49(4), pp. 633-342.

Sweat, M. et al., 2011. Community-based intervention to increase HIV testing and case detection in people aged 16-32 years in Tanzania, Zimbabwe, and Thailand (NIMH Project Accept, HPTN 043): a randomised study. *The Lancet Infectious Diseases*, 11(7), pp.525-532.

Swendeman, D. et al., 2009. Empowering sex workers in India to reduce vulnerability to HIV and sexually transmitted diseases. *Social Science & Medicine (1982)*, 69(8), pp.1157-1166.

Swift, C. & Levin, G., 1987. Empowerment: An emerging mental health technology. *The Journal of Primary Prevention*, 8, pp.71-94.

Szreter, S. & Woolcock, M., 2004. Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33(4), pp.650-667.

Tahzib, F., 1989. An initiative on vesicovaginal fistula. *Lancet*, 1(8650), pp.1316-1317.

Tarlov, A., 1996. Social Determinants of Health: The sociobiological translation. In *Health and Social Organisation: Towards and Health Policy for the 21st Century*. London, UK: Routledge, pp. 71-93.

Tawil, O., Verster, A. & O'Reilly, K.R., 1995. Enabling approaches for HIV/AIDS prevention: can we modify the environment and minimize the risk? *AIDS*, 9(12), pp.1299-1306.

Taylor, S.H. & Roberts, R.W., 1985. *Theory and practice of community social work*, New York: Columbia University Press.

Thaddeus, S. & Maine, D, 1994. Too far to walk: maternal mortality in context. *Social Science & Medicine*, 38(8), pp.1091-1110.



The Partnership for Maternal, Newborn and Child Health, 2011. *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and CHild Health*, Geneva, Switzerland: PMNCH.

The World Bank, 2006. *World Development Report 2006: Equity and Development*, New York: Oxford University Press.

The World Bank, 2010. *World Development Report 2010: Development and Climate Change*, Washington: The World Bank.

Titmuss, R.M., 2007. *Birth, Poverty and Wealth - A Study of Infant Mortality*, LaVergne, Tennessee: Lightning Source Inc.

Tonon, M.A., 1980. Concepts in community empowerment: a case of sanitary change in a Guatemalan village. *International Journal of Health Education*, 23(4), pp.1-16.

Torre, D.A., 1986. *Empowerment: structured conceptualization and instrument development*, Ithaca, NY: Cornell University.

Treno, A.J. & Holder, H.D., 1997. Community mobilisation: evaluation of an environmental approach to local action. *Addiction*, 92 Suppl 2, pp.S173-187.

Tripathy, P. et al., 2010. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *Lancet*, 375(9721), pp.1182-92.

Tripathy, P. et al., 2011. Community mobilisation with women's groups facilitated by Accredited Social Health Activists (ASHAs) to improve maternal and newborn health in underserved areas of Jharkhand and Orissa: study protocol for a cluster-randomised controlled trial. *Trials*, 12, p. 182.

United Nations Development Programme, 2009. *Human Development Report 2009*, New York: Palgrave Macmillan.

United Nations Children's Fund (UNICEF) & National Statistics Office (Malawi), 2006. *Malawi Multiple Indicator Cluster Survey 2006: Final Report*, New York: United Nations Children's Fund (UNICEF).

Victora, C.G. et al., 2003. Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet*, 362(9379), pp.233-241.

Wagenaar, A C, Murray, D M & Toomey, T L, 2000. Communities mobilizing for change on alcohol (CMCA): effects of a randomized trial on arrests and traffic crashes. *Addiction*, 95(2), pp.209-217.

Wagenaar, A C, Murray, D M, Gehan, J P, et al., 2000. Communities mobilizing for change on alcohol: outcomes from a randomized community trial. *Journal of Studies on Alcohol*, 61(1), pp.85-94.

Wagenaar, Alexander C. et al., 1999. Communities mobilizing for change on alcohol: Lessons and results from a 15-community randomized trial. *Journal of Community Psychology*, 27, pp. 315-326.

Wagstaff, A. & Claeson, M., 2004. *The Millennium Development Goals for Health: Rising to the Challenges*, Washington, DC: World Bank Publications.

Walker, G.J., 1985. Maternal mortality in Jamaica: A confidential inquiry in to all maternal deaths in Jamaica 1981-1983.

Wallerstein, N, 1992. Powerlessness, empowerment, and health: implications for health promotion programs. *American Journal of Health Promotion: AJHP*, 6(3), pp.197-205.

Wallerstein, N., 2002. Empowerment to reduce health disparities. *Scandinavian Journal of Public Health Suppl*, 59, pp.72-7.

Wallin, E., Gripenberg, J. & Andréasson, S., 2005. Over-serving at licensed premises in Stockholm: effects of a community action program. *Journal of Studies on Alcohol*, 66(6), pp. 806-814.

Wallin, E., Gripenberg, J. & Andréasson, S., 2002. Too drunk for a beer? A study of overserving in Stockholm. *Addiction (Abingdon, England)*, 97(7), pp.901-907.

Wallin, E., Norström, T. & Andréasson, S., 2003. Alcohol prevention targeting licensed premises: a study of effects on violence. *Journal of Studies on Alcohol*, 64(2), pp.270-277.

Wandersman, Abraham, 1981. A Framework of Participation in Community Organisations. *The Journal of Applied Behavioral Science*, 17(1), pp.27 -58.

Ward, J., 1987. Community development with marginal people: the role of conflict. *Community development Journal*, 22(1), pp. 18-21.

Wartenberg, T.E., 1992. *Rethinking Power*, New York: State University of New York Press.

Weil, M. & Gamble, D., 2005. Chapter 6: Evolution, Models, and the Changing Context of Community Practice. In *The Handbook of Community Practice*. London: Sage Publications Ltd.

Weil, M. & Gamble, D., 2002. Community practice models for the 21st century. In *Social worker's desk reference*. New York: Oxford University Press.

Werner, D., 1988. Empowerment and health.

Wheat, S., 1997. Banking on a better future. *Guardian Weekly*, (February), p.19.

World Health Organisation, 1986. *The Ottawa Charter for Health Promotion*, Geneva, Switzerland: World Health Organisation.

Wilkinson, R.G. ed., 2003. *Social Determinants of Health: The Solid Facts*, Geneva, Switzerland: World Health Organisation.

Woodard, G.B., Staff, S.D.H.C.D.T. & Labonte, R.N., 1999. *Working Upstream: Discovering Effective Practice for Community Development in Health*, Saskatchewan: University of Saskatchewan, News & Publications Office.

Woodroffe, C. et al., 1993. *Children, Teenagers, and Health: The Key Data*, Buckingham: Open University Press.

World Health Organisation, 2006. *Neonatal and perinatal mortality 2000*, Geneva: World Health Organisation.

World Health Organisation, United Nations Fund, United Nations Population Fund, The World Bank, 2007. *Maternal mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank*, The World Bank.

World Health Organisation, United Nations Fund, United Nations Population Fund, The world Bank, 2010. *Trends in Maternal Mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Washington, DC: The World Bank.

Yamin, A.E., 1996. Defining questions: situating issues of power in the formation of a right to health under international law. *Human Rights Quarterly*, 18(2), pp.398-438.

Zaba, B. et al., 2005. HIV and mortality of mothers and children: evidence from cohort studies in Uganda, Tanzania, and Malawi. *Epidemiology*, 16(3), pp.275-280.

Zimmerman, M A & Rappaport, J., 1988. Citizen participation, perceived control, and psychological empowerment. *American Journal of Community Psychology*, 16(5), pp.725-750.

Zimmerman, MA, 1990a. Toward a theory of learned hopefulness: A structural model analysis of participation and empowerment. *Journal of Research in Personality*, 1, pp.71-86.

Zimmerman, M.A., 1990b. Taking aim on empowerment research: On the distinction between individual and psychological concepts. *American Journal of Community Psychology*, 18, pp. 55-81.

Zimmerman, Marc A., 1995. Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology*, 23, pp.581-599.

## Appendix 1: Literature filter tool

### Conceptualisation of health – Which statement best describes how the community mobilisation intervention conceptualise health?

1	<p>The intervention conceptualises health as purely the absence of disease. Thus, the intervention targets the physiological risk factors that exist in communities.</p> <p><i>Definitions:</i>  <i>Physiological risk factors = These factors are physical, mechanical and biochemical in nature. Their impact is clearly evident in measureable or observable states of health such as epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. For example, malaria.</i></p> <p><i>Example:</i>  <i>Women and children are unhealthy because they suffer from malaria. As a result, the primary objective of the intervention is to provide pregnant women with SP.</i></p>
2	<p>The intervention conceptualises health predominantly as the absence of disease but also increasingly as the product of healthy lifestyle choices. Thus, the intervention predominantly targets physiological risk factors that exist in communities and also, increasingly, behavioural risk factors that exist in communities.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li><i>Physiological risk factors = These factors are physical, mechanical and biochemical in nature. Their impact is clearly evident in measureable or observable states of health such as epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. For example, malaria.</i></li> <li><i>Behavioural risk factors = These factors are the individual lifestyle behaviours that people engage in. For example, choosing whether to sleep under a bed net or not.</i></li> </ul> <p><i>Example:</i>  <i>Women and children are unhealthy because they suffer from malaria. As a result, the primary objective of the intervention is to provide women with SP. It may also attempt to educate women to change their behaviour and sleep under bed nets every night, but this is not the major component of the intervention package.</i></p>
3	<p>The intervention conceptualises health predominantly as the product of healthy lifestyle choices and behaviours and to a lesser extent as the absence of disease. Thus, the intervention targets the behavioural risk factors that exist in communities and also, to a lesser extent, the physiological risk factors that exist in communities.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li><i>Physiological risk factors = These factors are physical, mechanical and biochemical in nature. Their impact is clearly evident in measureable or observable states of health such as epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. For example, malaria.</i></li> <li><i>Behavioural risk factors = describe the individual lifestyle behaviours that people engage in. For example, choosing whether to sleep under a bed net or not.</i></li> </ul> <p><i>Example:</i>  <i>Women and children are unhealthy because they don't sleep under a bed net every night and so they suffer from malaria. As a result, the primary objective of the intervention is to educate women and children to change their behaviour and sleep under bed nets every night. It may also provide pregnant women with SP, but this is not the major component of the intervention package.</i></p>

4	<p>The intervention conceptualises health predominantly as the product of healthy lifestyle choices and behaviours and to a lesser extent as the product of multiple interrelated social, economic and environmental factors, which determine health status. To a lesser extent health is also conceptualised as the absence of disease. Thus, the intervention targets the behavioural risk factors that exist in communities and also increasingly targets the psycho-social risk factors and risk conditions that exist in communities. The physiological risk factors that exist in communities are also targeted to a lesser extent.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Physiological risk factors = These factors are physical, mechanical and biochemical in nature. Their impact is clearly evident in measureable or observable states of health such as epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. For example, malaria.</i></li> <li>• <i>Behavioural risk factors = describe the individual lifestyle behaviours that people engage in. For example, choosing whether to sleep under a bed net or not.</i></li> <li>• <i>Psycho-social risk factors = These factors are the individual cognitive or emotional states which are often reactions to the way people try to deal with their daily living situations and stressors in their lives. For example, lack of social support to engage in healthy behaviours</i></li> <li>• <i>Risk conditions = These conditions are the living situations of people that are structured by economic and political practices and by ideologies. For example, poverty.</i></li> </ul> <p><i>Example:</i>  <i>Women and children are unhealthy because they don't sleep under a bed net every night and so they suffer from malaria. As a result, the primary objective of the intervention is to educate women and children to change their behaviour and sleep under bed nets every night. It may also seek to reduce poverty and provide pregnant women with SP, but these are not the major components of the intervention package.</i></p>
5	<p>The intervention conceptualises health predominantly as the product of multiple interrelated social, economic and environmental factors, which determine health status. To a lesser extent health is also conceptualised as the product of healthy lifestyle choices and behaviours and as the absence of disease. Thus, the intervention targets the psycho-social risk factors and risk conditions that exist in communities and also, to a lesser extent, the behavioural and physiological risk factors that exist in communities.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Physiological risk factors = These factors are physical, mechanical and biochemical in nature. Their impact is clearly evident in measureable or observable states of health such as epidemiological measures of the incidence and prevalence of certain conditions in society and in outcome mortality and morbidity measures. For example, malaria.</i></li> <li>• <i>Behavioural risk factors = describe the individual lifestyle behaviours that people engage in. For example, choosing whether to sleep under a bed net or not.</i></li> <li>• <i>Psycho-social risk factors = These factors are the individual cognitive or emotional states which are often reactions to the way people try to deal with their daily living situations and stressors in their lives. For example, lack of social support to engage in healthy behaviours.</i></li> <li>• <i>Risk conditions = These conditions are the living situations of people that are structured by economic and political practices and by ideologies. For example, poverty.</i></li> </ul> <p><i>Example:</i>  <i>Women and children are unhealthy because they are poor and disadvantaged, which means they can't buy a mosquito net, so they don't sleep under one every night and so they suffer from malaria. As a result, the primary objective of the intervention is to reduce poverty. It may also seek to educate women and children to change their behaviour and sleep under a bed net every night and to provide pregnant women with SP, but these not the major components of the intervention package.</i></p>

## Goal – What goal is the community mobilisation intervention seeking to achieve?

1	<p>The intervention seeks to achieve task-oriented goals related to the eradication of specific health problems on behalf of communities. Individual community members are the target of these interventions.</p> <p><i>Definitions:</i>  <i>Task-oriented goals = the rational eradication of substantive problems that exist in the community</i></p> <p><i>Example:</i>  <i>The goal of the intervention is to reduce the incidence of malaria in women and children. The goal is to bring about individual change.</i></p>
2	<p>The intervention seeks to primarily achieve task-oriented goals related to the eradication of specific health problems on behalf of individuals in communities and increasingly process-oriented goals related to building the psychological capacities, such as knowledge and attitudes, of communities to promote self help and behaviour change. Individual community members are the primary target of these interventions although groups in the community are increasingly targeted.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Task-oriented goals = the rational eradication of substantive problems that exist in the community</i></li> <li>• <i>Process-oriented goals = the building of community capacity, integration and identity and thus to promote self-help</i></li> </ul> <p><i>Example:</i>  <i>The goal of the intervention is to reduce the incidence of malaria in women and children and also increasingly to develop the knowledge and skills and change the attitudes of women and children in the community about malaria prevention to encourage them to sleep under a bed net every night. The goal is to bring about individual and collective change.</i></p>
3	<p>The intervention seeks to achieve only process-oriented goals related to building the psychological capacities, such as knowledge and attitudes, of communities to promote self help and behaviour change. Groups in the community are the target of these interventions.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Task-oriented goals = the rational eradication of substantive problems that exist in the community</i></li> <li>• <i>Process-oriented goals = the building of community capacity, integration and identity and thus to promote self-help</i></li> </ul> <p><i>Example:</i>  <i>The goal of the intervention is to increase knowledge and skills and change the attitudes of women and children in the community about malaria prevention to encourage them to sleep under a bed net every night. The goal is to bring about collective change.</i></p>

	<p>The intervention seeks to achieve only process-oriented goals related to building the psychological capacities, such as knowledge and attitudes, of communities to promote self help and behaviour change and increasingly other process-oriented goals related to increasing the social capacities of a community to make choices and take control of health related issues. Groups in the community are the primary target of these interventions although the political system of the community is increasingly targeted.</p>
4	<p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Task-oriented goals = the rational eradication of substantive problems that exist in the community</i></li> <li>• <i>Process-oriented goals = the building of community capacity, integration and identity and thus to promote self-help</i></li> </ul> <p><i>Example:</i>  <i>The goal of the intervention is to increase knowledge and skills and change the attitudes of women and children in the community about malaria prevention to encourage them to sleep under a bed net every night. It also increasingly seeks to develop the capacity of the community to organise itself and take social action to lobby for more equitable bed net distribution by government health facilities. The goal is to bring about collective and political change.</i></p>
5	<p>The intervention seeks to achieve process-oriented goals related to increasing the social capacities of a community to make choices and take control of health related issues. The political system of the community is the target for these interventions. In the pursuit of these process-oriented goals these interventions also free up opportunities for the community to also address small-scale task-oriented goals that enable them to achieve their aims.</p> <p><i>Definitions:</i></p> <ul style="list-style-type: none"> <li>• <i>Task-oriented goals = the rational eradication of substantive problems that exist in the community</i></li> <li>• <i>Process-oriented goals = the building of community capacity, integration and identity and thus to promote self-help</i></li> </ul> <p><i>Example:</i>  <i>The goal of the intervention is to increase the capacity of the community to organise itself and take social action to lobby for more equitable bed net distribution by government health facilities. The goal is to bring about political change. In the short-term this social action enables the community to lobby for a regular supply of bed nets from the facility which it distributes to pregnant women and women with children to reduce the incidence of malaria. In the long-term the community becomes empowered to make choices and take control of all aspects of its own health.</i></p>



**Existing strengths and weaknesses – To what extent does the community mobilisation intervention build on existing strengths and weaknesses in communities?**

1	<p>The intervention defines the community as weak, suffering from substantive problems and unable to help itself. The role of the intervention is thus to solve the existing problems on behalf of the community.</p> <p><i>Example:</i>  <i>The community suffers from a high incidence of malaria and is incapable of helping itself in any way. The intervention involves giving members of the community members bed nets and malaria treatment.</i></p>
2	<p>The intervention defines the community as weak and lacking in skills. Although the intervention accepts that some capabilities do exist these are considered to be very minimal and not necessarily relevant and so the intervention seeks to solve the problems that exist on behalf of the community.</p> <p><i>Example:</i>  <i>The community suffers from a high incidence malaria and although it can do some things it cannot manage to significantly help itself in relation to malaria. The intervention involves giving community members bed nets and malaria treatment.</i></p>
3	<p>The intervention defines the community as fractured and lacking in skills but accepts that some relevant capabilities do exist. Thus, the intervention seeks to guide the community to marshal these existing resources to focus them on the problems that exist.</p> <p><i>Example:</i>  <i>The community suffers from a high incidence of malaria but has some resources that can enable it to address the malaria problem. The intervention involves giving community members bed nets and guiding them to utilise their existing labour resources to engage in mosquito breeding ground clearing activities.</i></p>
4	<p>The intervention defines the community as having adequate capabilities and some potential to solve its own problems. The intervention seeks to support the community to marshal some of these existing resources and focus them on the problems that exist as well as engaging in some reinforcement and strengthening of other capacities to enable the community to meet its own needs.</p> <p><i>Example:</i>  <i>The community suffers from a high incidence of malaria but has many resources that can enable it to address the malaria problem. The intervention involves giving community members bed nets and supporting them to utilise their labour resources to engage in mosquito breeding ground clearing activities. The intervention also involves reinforcing other capacities that can help to solve the problems that are present. For example: developing specific proposal writing skills; advocacy and resource mobilisation skills training; etc.</i></p>
5	<p>The intervention believes that the community already has all the potential to solve its own problems. Thus, the intervention seeks to extensively strengthen and reinforce these existing capacities to enable the community to meet its own needs.</p> <p><i>Example:</i>  <i>The community suffers from a high incidence of malaria but all the resources necessary to solve this problem already exist within the community. For example: labour to clear mosquito breeding grounds; money through contributions; literacy to write proposals for bed net donations; advocacy to lobby for better distribution; etc. Thus, the intervention involves: training community members in how best to clear mosquito breeding grounds; developing specific proposal writing skills; advocacy and resource mobilisation skills training; etc.</i></p>

## Target group – What groups are being reached by the community mobilisation intervention?

1	<p>The intervention reaches the whole community, defined geographically, as the 'client system'. The target group is defined as a broad entity.</p> <p><i>Example:</i> The intervention reaches the whole population of Mchinji District including: all genders; all ages; all tribes; all socio-economic statuses; etc.</p>
2	<p>The intervention reaches the whole community, defined geographically, as the 'client system' but also begins to reach some subparts of the community that are considered to be in need.</p> <p><i>Example:</i> The intervention reaches the whole community of Mchinji District and in particular reaches women and children.</p>
3	<p>The intervention reaches only some subparts of the community that are considered to be in need. The target group is defined as an intermediate entity - neither very broad nor very specific.</p> <p><i>Example:</i> The intervention reaches all women and children in the district.</p>
4	<p>The intervention reaches some subparts of the community that are considered to be in need and also begins to reach those subparts that are most marginalised.</p> <p><i>Example:</i> The intervention reaches all women and children in the district and in particular reaches rural women of childbearing age and neonatal children.</p>
5	<p>The intervention reaches only the most marginalised subparts within the community. These subparts suffer at the hands of the wider community and are thus in need of focussed support. The target group is defined as a very specific and targeted entity.</p> <p><i>Example:</i> The intervention reaches only rural women of childbearing age and neonatal children in the district who experience particularly high levels of morbidity and mortality due to the fact that they are not receiving equality of access to necessary resources and health services.</p>

**Level and area of participation – To what extent does the community have control over decision-making in the community mobilisation intervention**

1	<p>The intervention involves communities in decision-making by informing them of decisions made by external agents or asking the community for information. The community is not involved in decision-making about any aspects of the intervention process (e.g planning, implementation, evaluation, etc). The external agents are accountable for the decisions made.</p>
	<p><i>Example:</i>  <i>The external agents of the intervention decide that malaria is the most important problem facing women and children and should be addressed. The external agents inform the community of this and what they plan to do.</i></p>
2	<p>The intervention involves communities in decision-making through consultation about their views and opinions. These views and opinions are taken into account tokenistically to ensure buy in to the intervention by the community. The external agents are primarily accountable for the decisions made.</p>
	<p><i>Example:</i>  <i>The external agents consult the community about the problems facing women and children but do not use this information to decide which problems to address, these decisions have already been made, but the act of consulting the community encourages buy in. The external agents have already decided that malaria is the most important problem facing women and children and should be addressed.</i></p>
3	<p>The intervention involves communities in decision-making through consultation about their views and opinions. These views and opinions are taken into account along with other factors when the external agents make decisions. The community is involved in decision-making about some aspects of intervention process (e.g planning, implementation, evaluation, etc). The external agents are primarily accountable for the decisions made although the community also takes some responsibility.</p>
	<p><i>Example:</i>  <i>The external agents consult the community about the problems facing women and children and use this information to decide that malaria is the most important problem facing women and children and should be addressed.</i></p>
4	<p>The intervention involves the external agents and the community collaborating closely to jointly make decisions. The external agents and the community are jointly accountable for the decisions made.</p>
	<p><i>Example:</i>  <i>The external agents and the community jointly decide that malaria is the most important problem facing women and children and should be addressed.</i></p>
5	<p>The intervention is driven by the community so that they lead all decisions made. The external agents support this process. The community is involved in making decisions about all aspects of the intervention process (e.g planning, implementation, evaluation, etc). The community is solely accountable for the decisions made.</p>
	<p><i>Example:</i>  <i>The community decides that malaria is the most important problem facing women and children and should be addressed and inform the external agent of this and how they can assist the community.</i></p>

## Role of external agent – What is the external agent’s role in the community mobilisation intervention?

1	<p>In the intervention the role of the external agent is to solve the health problems being faced by the community, on behalf of the community. The external agent is the ‘owner’ of the intervention process.</p> <p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The external agent gives bed nets to the community to reduce the incidence of malaria.</i></p>
2	<p>In the intervention the role of the external agent is both to solve some problems on behalf of the community and also to bring the community together to marshal collective capacities to solve other problems. The external agent is the 'owner' of the intervention process but the community is beginning to take joint ownership over some aspects.</p> <p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The external agent gives bed nets to the community to reduce the incidence of malaria. As another component of the intervention, the external agent brings individuals in the community together to discuss the problem of malaria affecting women and children and organise the labour force in the community for mosquito breeding ground clearing activities.</i></p>
3	<p>In the intervention the role of the external agent is to bring community members together to identify and marshal the collective capacities that exist to solve the problems being faced. The external agent and community are joint ‘owners’ of the intervention process.</p> <p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The external agent brings individuals in the community together to discuss the problem of malaria affecting women and children and organise the labour force in the community for mosquito breeding ground clearing activities.</i></p>

4	<p>In the intervention the role of the external agent is to bring community members together to identify and marshal the collective capacities that exist to solve the problems being faced. The external agents also act as a resource that the community can draw on if and when support is needed. When the external agents are called in they help to reinforce and strengthen the capacities that the community identifies it needs to address the problems being faced. The external agent and community are joint ‘owners’ of the intervention process but the community is beginning to take more ownership.</p>
	<p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The external agent brings individuals in the community together to discuss the problem of malaria affecting women and children and organise the labour force in the community for mosquito breeding ground clearing activities. As another component of the intervention the external agent provides proposal writing skills training on the request of the community who wishes the use these skills to more successfully mobilise funding to buy bed nets for women and children in the community. As a result of this the community manages to buy its own nets.</i></p>
5	<p>In the intervention the role of the external agent is to act as a resource that the community can draw on if and when support is needed. When the external agents are called in they help to reinforce and strengthen the capacities that the community identifies it needs to address the problems being faced. The intervention process is ‘owned’ and led by the community.</p>
	<p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The external agent provides proposal writing skills training on the request of the community who wishes the use these skills to more successfully mobilise funding to buy bed nets for women and children in the community. As a result of this the community manages to buy its own nets.</i></p>

## Role of community – What is the role of the community in the community mobilisation intervention?

1	<p>In the intervention the role of the community is passive. The community is simply the geographical location in which the intervention is implemented. As such the intervention is imposed from outside the community to solve the problems being faced.</p> <p><i>Example:</i>  <i>Bed nets are distributed through a health centre in the community.</i></p>
2	<p>In the intervention the role of the community is passive. The community is simply the system that the intervention is targeting for change. As such the intervention is imposed from outside the community to solve the problems being faced.</p> <p><i>Example:</i>  <i>Malaria is viewed as a problem affecting the community and thus bed nets are distributed by an external organisation in an attempt to create a healthy community environment through the eradication of malaria.</i></p>
3	<p>In the intervention the role of the community is that of an increasingly active resource from which the solutions to the problems being faced can be gathered. The community works with an external agent who helps to draw out the resources that will help to address specific problems but the external agent also imposes some external solutions as well.</p> <p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The community comes together, under the direction of the external agents, to discuss the problem of malaria affecting women and children and organise the labour force in the community for mosquito breeding ground clearing activities. The external agent also provides some bed nets to the community.</i></p>
4	<p>In the intervention the role of the community is active. The community is the primary source of solutions to the problems being faced. The community works with an external agent who helps to draw out the resources that will help to address specific problems and also engages in some degree of capacity building so that the community can begin to solve the problems it is facing itself. The external agent imposes few if any external solutions.</p> <p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The community comes together, under the direction of the external agents, to discuss the problem of malaria affecting women and children and organise the labour force in the community for mosquito breeding ground clearing activities. At the same time the community lobbies with the external agents to receive proposal writing skills training so that they can more successfully mobilise funding to buy bed nets for the women and children in the community.</i></p>

	<p>In the intervention the role of the community is active. The community is the only source of solutions to the problems being faced. The community is the active agent of change and itself seeks out support from the external agent to build on the capacities it already has to solve the problems it is facing. The external agent imposes no external solutions.</p>
5	<p><i>Definitions:</i>  <i>External agents = are the organisations and all officers of the organisations working for or with the community to bring about changes in health</i></p> <p><i>Example:</i>  <i>The community actively lobbies with the external agents to receive proposal writing skills training so that they can more successfully mobilise funding to buy bed nets for the women and children in the community.</i></p>

## Tools and methods – What are the tools and methods employed by the community mobilisation intervention?

1	<p>The intervention utilises methods that seek to eradicate or eliminate the negative factors in the community that are causing the health problems being faced. This involves methods that act on physiological pathways. The timeframe needed to implement these methods is relatively short.</p> <p><i>Example:</i> The main method used by the intervention is the provision of LA to treat cases of malaria.</p>
2	<p>The intervention utilises methods that seek to eradicate or eliminate the negative factors in the community that are causing the health problems being faced. This involves methods that act on physiological pathways. The intervention also begins to utilise methods that seek to harness the positive cognitive factors that already exist in the community and that can help to address the problems faced. This involves methods that change health behaviours or levels of health knowledge of groups in communities.</p> <p><i>Example:</i> The main method used by the intervention is the provision of LA to treat cases of malaria. In addition, the intervention package contains a component of health education to encourage women and children to sleep under bed nets and go to the health facility to receive LA when they have malaria.</p>
3	<p>The intervention utilises methods that seek to harness the positive cognitive factors that already exist in the community and that can help to address the problems faced. This involves methods that change health behaviours or levels of health knowledge of groups in communities. The timeframe needed to implement these methods is moderate.</p> <p><i>Example:</i> The main method used by the intervention is the provision of health education to encourage women and children to sleep under bed nets and go to the health facility to receive LA when they have malaria.</p>
4	<p>The intervention seeks to harness the positive cognitive factors that already exist in the community and that can help to address the problems faced. This involves methods that change health behaviours or levels of health knowledge of groups in communities. The intervention begins to utilise methods that seek to build on other positive social factors that already exist in the community and that can help to address the problems faced. This involves methods that seek to build the social capacities of the community to make decisions and take control of its health.</p> <p><i>Example:</i> The intervention package contains a component of health education to encourage women and children to sleep under bed nets and go to the health facility to receive LA when they have malaria. It also seeks to build the capacity of communities to take control of MCH in relation to malaria. For example, the community lobbies for literacy skills training and uses this to write proposals for donations of bed nets. The proposals are successful and bed nets, LA and health education regarding malaria are provided by a local partner.</p>



5	<p>The intervention utilises methods that seek to build on positive social factors that already exist in the community and that can help to address the problems faced. This generally involves methods that seek to build the social capacities of the community to make decisions and take control of its health. Through these methods the community may develop the capacity to employ other methods that eradicate or eliminate negative factors or harness positive cognitive or social factors. The timeframe needed to implement these methods is relatively long-term.</p> <p><i>Example:</i>  <i>The intervention builds the capacity of communities to take control of MCH in relation to malaria. For example, the community lobbies for literacy skills training and uses this to write proposals for donations of bed nets. The proposals are successful and bed nets, LA and health education regarding malaria are provided by a local partner.</i></p>
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**Resource mobilisation – Who mobilises the resources brought to bear directly on the health issue of importance by the community mobilisation intervention?**

1	<p>The resources that the intervention brings to bear directly on the health issue of importance are all mobilised by the external agent and brought in to assist the community</p> <p><i>Definitions:</i>  <i>Resources = financial, symbolic, human, knowledge and skills, natural, etc. These are the resources used by the intervention to directly address the health issues present in the community.</i></p> <p><i>Example:</i>  <i>The external agent builds a clinic in the community. All costs of the clinic are covered by the external agent or through funds mobilised by the external agent.</i></p>
2	<p>The resources that the intervention brings to bear directly on the health issue of importance are mobilised predominantly by the external agent and brought in to assist the community but some resources may also be mobilised by the community itself from within and/or outside</p> <p><i>Definitions:</i>  <i>Resources = financial, symbolic, human, knowledge and skills, natural, etc. These are the resources used by the intervention to directly address the health issues present in the community.</i></p> <p><i>Example:</i>  <i>The external agent builds a clinic in the community. The majority of costs are covered by the external agent or through funds mobilised by the external agent. The community contributes a small percentage of the overall cost of the clinic through 'in kind' contributions such as moulding bricks and labour.</i></p>
3	<p>The resources that the intervention brings to bear directly on the health issue of importance are mobilised equally by the external agent and brought in to assist the community and by the community itself from within and/or outside</p> <p><i>Definitions:</i>  <i>Resources = financial, symbolic, human, knowledge and skills, natural, etc. These are the resources used by the intervention to directly address the health issues present in the community.</i></p> <p><i>Example:</i>  <i>The external agent and the community collaborate to build a clinic. Half the costs are covered by the external agent or through funds mobilised by the external agent. The community contributes the other half of the overall costs of the clinic through 'in kind' contributions such as moulding bricks and labour.</i></p>
4	<p>The resources that the intervention brings to bear directly on the health issue of importance are mobilised predominantly by the community itself from within and/or outside. The external agent may support the community and act as a broker for these resources and may also mobilise some resources and bring them in to assist the community.</p> <p><i>Definitions:</i>  <i>Resources = financial, symbolic, human, knowledge and skills, natural, etc. These are the resources used by the intervention to directly address the health issues present in the community.</i></p> <p><i>Example:</i>  <i>The community builds a clinic. The majority of costs are covered by the community through 'in kind' contributions or through funds mobilised by proposals written by the community itself. The external agent provides technical advice to the community on proposal writing and puts the community in contact with potential funders. The external agent also independently mobilises a small percentage of the overall costs and contributes them to the building project.</i></p>

5	<p>The resources that the intervention brings to bear directly on the health issue of importance are all mobilised by community itself from within and/or outside. The external agent may support the community and act as a broker for these resources but does not itself mobilise resources and bring them in to assist the community</p> <p><i>Definitions:</i></p> <p><i>Resources = financial, symbolic, human, knowledge and skills, natural, etc. These are the resources used by the intervention to directly address the health issues present in the community.</i></p> <p><i>Example:</i></p> <p><i>The community builds a clinic. All the costs are covered by the community through 'in kind' contributions or through funds mobilised by proposals written by the community itself. The external agent provides technical advice to the community on proposal writing and puts the community in contact with potential funders.</i></p>
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## **Appendix 2: Semi-structured observation schedule**

### **1. Describe the environment**

- Where are we?
- Why are we here?
- How are people behaving?
- What kind of behaviour is acceptable here?
- What kind of behaviour is not acceptable here?

### **2. Describe the participants**

- Who is here
- How many people are here?
- Describe the roles of each person in the setting?
- Why are they here?
- Who is allowed to be here?
- Who is not allowed to be here?

### **3. Describe the activities and interactions**

- What physiological, behavioural and socio-environmental inputs/activities are being provided?
- What physiological, behavioural and socio-environmental immediate outcomes emerging?
- What physiological, behavioural and socio-environmental intermediate outcomes emerging?
- What physiological, behavioural and socio-environmental long-term outcomes emerging?
- Are things happening in any particular order or sequence?
- Are things happening in a random way?
- How do people interact with each other non-verbally?
- How do people feel interacting with each other?
- Do people interact differently with different people or the same with everybody?
- How are people engaging with the task they are there to do?
- Do people engage with the task in the same way or differently?
- How are the manuals, tools, picture cards and stationery being used?
- How do you compare what is happening to what should happen?

### **4. Describe the frequency and duration of activities**

- How long did each 'event' last?
- To what extent do the events happen repeatedly?

**5. Describe the less obvious things**

- Do the participants use words that only they will understand? Describe this?
- Is the event open or closed?
- Are there any obvious meanings behind the actions or conversations?
- Do the people have a group identity? How do you know this?
- What does not happen, but should?

### **Appendix 3: Semi-structured focus group discussion schedules**

#### **CONSENT**

Find a quiet place to sit and chat away from other people. Chat a little bit to help the respondents feel relaxed. Then read out the following before you start the focus group:

Hello. My name is ..... and I am helping Mikey Rosato from the Institute of Child Health in London with his research of women's groups.

We were hoping to interview you because we are interested to know more about the women's group in this community. We feel that you are in the best position to help us with this information and we think your feelings and opinions are very important. Your ideas will help us learn and understand and so improve the women's groups and make them better.

The focus group will last approximately 1 hour and you can stop it at any time and ask questions at the end. If there are any questions you do not want to answer you do not have to answer them. There are no right or wrong answers to these questions. If you do not understand a question please ask me to repeat or explain it. Your answers will have no negative effect on you or your family so please feel free to tell me how you feel.

Everything you say will be absolutely confidential and will only be shared with Mikey Rosato. No one else in MaiMwana will have access to the information.

We would really appreciate your cooperation but you are free to choose not to participate. Your participation or non-participation will have no negative effect on you or your family.

Do you have any questions?

***Are you happy to continue with the focus group?***

Before we continue I would like to tape record the focus group because I want to remember all the things you say. This tape recording will be absolutely confidential and will only be shared with Mikey Rosato. No one else in MaiMwana will have access to the information. The tape will be cleared after we have used it.

Do you have any questions?

***Are you happy for me to record the focus group?***

**RESPONDENT CHARACTERISTICS**

<b>Respondent</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Parity</b>	<b>Role</b>
<b>1</b>					
<b>2</b>					
<b>3</b>					
<b>4</b>					
<b>5</b>					
<b>6</b>					
<b>7</b>					
<b>8</b>					
<b>9</b>					
<b>10</b>					
<b>11</b>					
<b>12</b>					

## **PARTICIPATION**

*Discuss a common understanding of participation*

- 1. List the activities MaiMwana and your women's group has done to encourage participation in MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to participation?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to participation?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**



## **LEADERSHIP**

*Discuss a common understanding of leadership*

- 1. List the activities MaiMwana and your women's group has done to encourage leadership of MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to leadership?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to leadership?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## **ORGANISATIONAL STRUCTURES**

*Discuss a common understanding of organisational structures*

- 1. List the activities MaiMwana and your women's group has done to develop organisational structures for MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to organisational structures?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to organisational structures?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## NEEDS ASSESSMENT

*Discuss a common understanding of needs assessment*

- 1. List the activities MaiMwana and your women's group has done to encourage needs assessment of MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to needs assessment?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to needs assessment?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## **ASKING WHY?**

*Discuss a common understanding of asking why?*

- 1. List the activities MaiMwana and your women's group has done to encourage asking why for MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to asking why?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to asking why?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## RESOURCE MOBILISATION

*Discuss a common understanding of resource mobilisation*

- 1. List the activities MaiMwana and your women's group has done to encourage resource mobilisation for MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to resource mobilisation?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to resource mobilisation?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## **LINKS WITH OTHERS**

*Discuss a common understanding of links with others*

- 1. List the activities MaiMwana and your women's group has done to encourage links with others for MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to links with others?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to links with others?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## **EXTERNAL AGENTS**

*Discuss a common understanding of external agents*

- 1. List the activities MaiMwana and your women's group has done to develop the capacities of people to take control of MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to taking control of MCH issues?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to taking control of MCH issues?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**

## **PROGRAMME MANAGEMENT**

*Discuss a common understanding of programme management*

- 1. List the activities MaiMwana and your women's group has done to encourage programme management of MCH issues in this community.**

*Group the activities. Consider one group at a time and explore:*

- 2. How did this activity change the knowledge, awareness, skills and attitudes of members of this community in relation to programme management?**
- 3. How did these changes in knowledge, awareness, skills and attitudes change the behaviour and practices of members of this community in relation to programme management?**
- 4. How did these changes in behaviour and practice impact on the community as a whole?**
- 5. How might these community impacts improve MCH and reduce mortality?**



#### **Appendix 4: Abstracts of selected peer reviewed publications**

## Women's groups' perceptions of maternal health issues in rural Malawi

*Mikey Rosato, Charles W Mwansambo, Peter N Kazembe, Tambosi Phiri, Queen S Soko, Sonia Lewycka, Beata E Kunyenge, Stefania Vergnano, David Osrin, Marie-Louise Newell, Anthony M de L Costello*

## Alma-Ata: Rebirth and Revision 5

### Community participation: lessons for maternal, newborn, and child health

*Mikey Rosato, Glenn Laverack, Lisa Howard Grabman, Prasanta Tripathy, Nirmala Nair, Charles Mwansambo, Kishwar Azad, Joanna Morrison, Zulfiqar Rhytta, Henry Peru, Susan Rifkin, Anthony Costello*

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**Rosato M<sup>1</sup>, Lewycka S<sup>1</sup>, Mwansambo C<sup>2</sup>, Kazembe P<sup>3</sup>, Costello A<sup>1</sup>**

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3. Baylor-Abbott Clinical Centre of Excellence

STUDY PROTOCOL

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# A cluster randomised controlled trial of the community effectiveness of two interventions in rural Malawi to improve health care and to reduce maternal, newborn and infant mortality

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## Abstract

**Background:** The UN Millennium Development Goals call for substantial reductions in maternal and child mortality, to be achieved through reductions in morbidity and mortality during pregnancy, delivery, postpartum and early childhood. The MaiMwana Project aims to test community-based interventions that tackle maternal and child health problems through increasing awareness and local action.

**Methods/Design:** This study uses a two-by-two factorial cluster-randomised controlled trial design to test the impact of two interventions. The impact of a community mobilisation intervention run through women's groups, on home care, health care-seeking behaviours and maternal and infant mortality, will be tested. The impact of a volunteer-led infant feeding and care support intervention, on rates of exclusive breastfeeding, uptake of HIV-prevention services and infant mortality, will also be tested. The women's group intervention will employ local female facilitators to guide women's groups through a four-phase cycle of problem identification and prioritisation, strategy identification, implementation and evaluation. Meetings will be held monthly at village level. The infant feeding intervention will select local volunteers to provide advice and support for breastfeeding, birth preparedness, newborn care and immunisation. They will visit pregnant and new mothers in their homes five times during and after pregnancy. The unit of intervention allocation will be clusters of rural villages of 2500-4000 population. 48 clusters have been defined and randomly allocated to either women's groups only, infant feeding support only, both interventions, or no intervention. Study villages are surrounded by 'buffer areas' of non-study villages to reduce contamination between intervention and control areas. Outcome indicators will be measured through a demographic surveillance system. Primary outcomes will be maternal, infant, neonatal and perinatal mortality for the women's group intervention, and exclusive breastfeeding rates and infant mortality for the infant feeding intervention. Structured interviews will be conducted with mothers one-month and six-months after birth to collect detailed quantitative data on care practices and health-care-seeking. Further qualitative, quantitative and economic data will be collected for process and economic evaluations.

**Trial registration:** ISRCTN06477126

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**MaiMwana women's groups: a community mobilisation intervention to improve mother and child health and reduce mortality in rural Malawi**

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**Abstract**

***Aim***

To describe in detail a participatory intervention involving women's groups in rural Mchinji District, Malawi, currently being evaluated through a cluster randomized controlled trial.

***Methods***

A wide range of quantitative methods including surveys and monitoring forms and qualitative methods including observation, focus group discussions and interviews.

***Results***

A women's group intervention involving over 12 000 women and men in 207 groups across 310 villages has been implemented in Mchinji District, Malawi, since May 2005. The intervention aims to build the capacities of communities to take control of the mother and child health issues that affect them. The primary target population are women of childbearing age. The women's group intervention comprises groups, members, a cycle of meetings, participatory rural appraisal tools; and picture cards. Significant resource inputs include facilitators and supervisors who receive a salary, training and equipment and materials to support the groups.

***Conclusion***

Women's groups focusing on maternal and infant care and health have been successfully introduced in a large rural population in Mchinji district. It is hypothesized that the groups will catalyse community collective action to address mother and child health issues and improve the health and reduce the mortality of mothers and children. Their impact will be reported in late 2010.

Current controlled trials ISRCTN06477126

**Strategies developed and implemented by women's groups to improve mother and infant health and reduce mortality in rural Malawi**

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**Abstract**

We evaluated the strategies to tackle maternal and infant health problems developed by women's groups in rural Malawi.

Quantitative data were analyzed on strategies developed by 184 groups at two of the meetings in the community action cycle (attended by 3365 and 3047 women). Data on strategies implemented was collected through a survey of the 197 groups active in January 2010. Qualitative data on the identification and implementation of strategies was collected through 17 focus group discussions and 12 interviews with men and women.

To address the maternal and child health problems identified the five most common strategies identified included: health education sessions, bicycle ambulances, training of traditional birth attendants, wetland vegetable garden (dimba garden) cultivation and distribution of insecticide treated bednets (ITNs). The five most common strategies actually implemented included: dimba garden cultivation, health education sessions, ITN distribution, health programme radio listening clubs and clearing house surroundings. The rationale behind the strategies and the factors facilitating and hindering implementation are presented.